AMERICAN MEDICAL TIMES

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The Preliminary Term for the Session of 1861–2, will commence on MONDAY, SEPTEMBER 23, and continue four weeks, until the opening of the Regular Term in October.

The Regular Term will commence on MONDAY, OCTOBER 21, and continue until the *second* Thursday of March, following.

Fees for a Full Course of Lectures, $105; Matriculation, $5; Graduation, $30.

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of 1861–62 will begin on Wednesday, the 2d day of October, 1861, and continue sixteen weeks.

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Emeritus Prof. of Chemistry and Pharmacy.

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" Gunshot Wounds.....Prof. Raphael.
" The Anatomy of the female pelvis and fœtal head...Prof. C. A. Budd.
" Infantile Fevers.....Prof. Jacobi.
" The diagnosis of Uterine Diseases.....Prof. Noeggerath.
" The use of the Ophthalmoscope.....Prof. Holcomb.

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Tuesdays—Diseases of Children.....Prof. Jacobi.
Wednesdays—Diseases of Women.....Profs. Noeggerath and C. A. Budd.
Thursdays—Surgical.....Prof. Carnochan.
Fridays—Diseases of Children.....Prof. Jacobi.
Saturdays—Medical.....Prof. C. A. Budd.

Due notice will be given of the Commencement of the Winter Course. For further information, apply to

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University of New York Medical Department.

Session, 1861–2.

The Session for '61–62 will begin on Monday, October 21, and will be continued until the 1st of March.

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BUFFALO, *Sept.* 1861.

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PROFESSOR OF THE PRINCIPLES AND PRACTICE OF MEDICINE.

LECTURE II.

Recapitulation of the Subjects relating to Percussion considered in the preceding Lecture.—Exaggerated Vesicular Resonance in Emphysema and Tympanitic Resonance in Pneumo-hydrothorax again illustrated and contrasted.—The Application of Percussion to the Diagnosis of Emphysema.—Application of Percussion to the Diagnosis of Pneumo-hydrothorax.—Application to determine the Presence of Liquid in the Pleural Sac in Pneumo-hydrothorax, Pleurisy, Empyema, and Hydro-thorax.—Vesiculo-tympanitic Resonance over Lung floating on Liquid.—Percussion in Pneumonia, Œdema of the Lungs, Pulmonary Apoplexy, Carcinoma, etc.—Importance of the Negative Information obtained by Percussion in Bronchitis, Asthma, Intercostal Neuralgia, Pleurodynia, Affections of the Larynx, etc.

GENTLEMEN:—In my last lecture I pointed out the sources of the important differences by which different sounds are distinguished, viz. intensity, pitch, and quality. I endeavored to make clear the points of difference denoted by these three terms. I trust that I succeeded in so doing, for you will find that a complete and accurate knowledge of the physical signs obtained by percussion and auscultation, involves an appreciation of distinctive characters derived from these sources. Entering upon the consideration of percussion, we considered, as the point of departure for the study of the signs of disease obtained by this method, the signs pertaining to the healthy chest. We analysed the sound produced by striking upon the healthy chest, called the *normal vesicular resonance*, and we found it to be a low pitched sound, varying in intensity according to the force of the blow and other circumstances, and possessing a peculiar quality—a quality not to be described in words or imitated, but which the ear quickly learns to appreciate, and which we have called the vesicular quality. Bear in mind the fact implied in this name, viz. this peculiar quality of sound is due to the peculiar structure of the lungs by which the air giving rise to the resonance is contained in an immense number of minute spaces called the air vesicles. Next were considered the variations in different healthy persons, as regards the normal vesicular resonance, and the normal variations between the two sides of the chest. Proceeding, then, to the signs of disease, it was found that these are only five in number, to wit, exaggerated vesicular resonance, diminished resonance or dulness, absence of resonance or flatness, tympanitic and vesiculo-tympanitic resonance. Exaggerated vesicular resonance was stated to be an important sign in one affection only, viz. pulmonary or vesicular emphysema. This sign was illustrated in several patients affected with emphysema, who were introduced into the amphitheatre. Next, tympanitic resonance was illustrated by a case of pneumo-hydrothorax.

I shall now proceed to explain and illustrate further these five signs, as they are presented in different forms of disease, considering their differential characters, their significance, and their diagnostic value. Taking up, as I shall do in this course of lectures, the signs belonging to each of the different methods of exploration separately, I shall direct your attention to the signs belonging to the particular method under consideration, as they are presented in the cases which I shall bring before you. It is a striking and beautiful feature of physical exploration, that signs from the different methods are brought together in diagnosis. We do not rely upon signs obtained by percussion on any of the methods singly, but we employ in conjunction several or all the methods. In this way information obtained by any one method is corroborated by that furnished by other methods; and, on the other hand, incomplete or erroneous conclusions which might be drawn from the information obtained by a single method, are rendered complete or corrected by the combination of signs furnished by the different methods collectively. In the clinical study of the cases which we shall observe together during the session in this hospital, we shall bring to bear upon the diagnosis all the physical signs available, always considering them in connexion with the symptoms, for the latter are by no means to be overlooked in bestowing due attention on the former; but at present it would beget confusion to anticipate the subjects of future lectures by speaking of signs which have not been considered. As we proceed in our course, it will be useful to point out the correlation of the signs under consideration with those which have been considered, but it is obvious that to go in advance of the subjects under consideration would be embarrassing to the student.

I have illustrated exaggerated vesicular resonance and tympanitic resonance as these signs are presented in several cases of emphysema, and in a case of pneumo-hydrothorax. I wish now to consider more fully the application of these signs to the diagnosis of these two affections. I shall therefore again introduce one of the patients affected with emphysema, and the patient affected with pneumo-hydrothorax. I strike upon the chest of each of the two patients as they stand before you, and you have again an illustration of these two signs contrasted with each other. The essential difference consists, as you perceive, in the entire absence of the vesicular quality of sound in the case of pneumo-thorax, and in the presence of a certain amount of the vesicular quality of sound in the case of emphysema. I wish you to notice that in both cases the sound is intense; in both, in fact, there is exaggerated resonance, but in one case the resonance is purely tympanitic or non-vesicular, while in the other the vesicular quality is apparent. The vesicular quality, however, in the case of emphysema is not strongly marked; it is less marked than in health, and this is always true of the resonance in that affection. The vesicular quality of sound is uniformly lessened, and the pitch of the sound is raised in emphysema. In other words, the resonance is properly a vesiculo-tympanitic resonance.

To what extent is percussion applicable in the diagnosis of emphysema? Percussion alone, without any knowledge of the history or symptoms of a case, would very rarely, if ever, warrant a positive diagnosis. But, taking the information obtained by percussion in connexion with certain laws of the disease, viz. that it affects the upper lobes especially or exclusively; that it affects generally both sides, and that the lung on one side is usually affected to a greater extent than that on the other side; moreover, taking into view the history and symptoms, and bringing percussion to bear or the exclusion of other affections, the diagnosis could often be made with much confidence. We shall see, however, that other methods, viz. inspection and auscultation, furnish most important information, and of this information we should not, of course, fail to avail ourselves.

Here is an important fact to be kept in mind: An exaggerated vesicular resonance is one of the signs of emphysema, but emphysema does not invariably give rise to an exaggerated resonance. The amount of the emphysema, in some cases, prevents exaggeration of the resonance. When the increase in the volume of the lung is so great as to dilate and render extremely tense the thoracic walls, the sound is deadened precisely as the sound of a drum too strongly tightened is deadened. In such a case the reso-

nance will be vesiculo-tympanitic, but not exaggerated. Such cases are exceptions to the rule.

Another point connected with percussion in emphysema is to be mentioned: Emphysema may be limited to one side, and, as I have stated, when it exists on both sides, as it usually does, it is generally greater on one side than on the other. Now, if we were to be guided alone by the information obtained by percussion, we might be liable to the error of supposing the exaggerated resonance, which is either limited to or greater on one side, to be the normal resonance proper to the person examined, and that diminished resonance or dulness exists on the other side. Due attention to other signs will prevent this error.

To what extent is percussion applicable in the diagnosis of pneumo-hydrothorax? A non-vesicular or tympanitic resonance existing on one side in a case in which the previous history and symptoms point to the occurrence of perforation of lung, renders the presumption strong that the pleural sac contains air. But the proof is not complete. A tympanitic resonance considerably intense is sometimes produced by percussing over solidified lung. In pneumo-hydrothorax, however, other signs are generally associated which are highly characteristic, and render the diagnosis positive. These signs are obtained by other methods, viz. auscultation and percussion, and will be considered when we come to treat of these methods. In this affection liquid and air are contained in the pleural sac. Pneumo-thorax, *i. e.* air without liquid, very rarely exists. Now, the fact that both liquid and air are contained in the pleural sac, is demonstrated by a mode of applying percussion which I will illustrate in the case before you; and this will lead us to speak of the signs of liquid which are obtained by percussion.

In the case of pneumo-hydrothorax before you, a certain portion of the pleural space is occupied with liquid, and another portion with air. The liquid gravitates, of course, to the bottom of the chest, and rises to a certain height. The air, of course, is above the liquid, and the pressure of the air and liquid combined, condenses the lung, and carries it upwards into the superior posterior portion of the chest. I now percuss on the anterior surface of the affected side from above downwards. The intense tympanitic resonance continues until I come to a point about on a level with the nipple; here the resonance ceases, and below this point we have absence of resonance or flatness extending to the base of the chest. This flatness denotes the presence of liquid. What is the evidence of this? The patient is now standing; the body is in a vertical position. The point, where the tympanitic resonance ceases, is not far from the level of the liquid. Percussing from above downwards around the chest, marking with ink the points where the tympanitic resonance ceases, and then connecting together the points, you see I make a horizontal line around the affected side of the chest. This may be considered as representing the level of the liquid. I now change the position of the patient by causing him to lie on his back on the table before me. In this position the liquid in the chest should change its level; it should gravitate to the posterior part of the chest, and the air above should extend anteriorly from the summit to the base of the chest. Let us see if percussion shows this to be so. I percuss now from above downwards, and, as you perceive, an intense tympanitic resonance is obtained everywhere over the anterior surface of the affected side. I now cause the patient to rise, and again take the standing posture. Repeating the percussion, the tympanitic resonance now extends from the summit only to the horizontal line which I have previously delineated on the chest in ink.

By this procedure we have demonstrative proof of the presence of liquid with air in this case. But it does not show with exactitude the relative spaces occupied by the air and liquid. The horizontal line of flatness when the patient stands is not precisely at the surface of the liquid, for the tympanitic resonance is propagated somewhat below the surface. This is a fact to be borne in mind. If the quantity of liquid be small, we may not obtain evidence of its presence by percussion, because the tympanitic resonance is propagated over the whole of the affected side. If, however, the quantity be considerable, this test is available.

I pass to speak of the application of percussion to determine the existence of liquid in the pleural sac, in other affections than pneumo-hydrothorax. Liquid exists in this situation in pleurisy, in empyema, which is only a variety of pleurisy, and in hydrothorax. I shall introduce two patients affected with pleurisy. In one of these patients the right side of the chest is nearly filled with liquid. What is the evidence of this? I percuss the chest. On the left side we have everywhere the normal vesicular resonance, and on the affected side we have everywhere absence of resonance or flatness. Is this flatness proof positive that the side is filled with liquid? It is not; yet it is very strong evidence, for the probability is extremely slight that the whole of one lung is solidified sufficiently to give rise to this universal flatness on one side, in a patient with a chronic affection and able to be up and about, as is this patient. Indeed, it is rare that solidification of an entire lung is so complete as to yield no sound on percussion; usually there is air enough in the bronchial tubes and in some of the air cells to permit some resonance, which is either tympanitic or vesiculo-tympanitic. Still, such a condition is possible, and there might possibly be a tumor filling the whole of the affected side. Therefore, to arrive at a positive diagnosis, other signs are to be obtained by auscultation, inspection, and palpation, which will be considered in treating of these methods.

In the other patient the affected side is not filled with liquid. About two-thirds of the left side are occupied with liquid, and the lung is expanded to occupy the remaining space. Now in this case the same procedure may be employed to determine the presence of liquid, as in the case of pneumo-hydrothorax. As the patient stands I percuss from above downwards, until the vesicular resonance ceases, and gives place to flatness. The upper limit of the flatness denotes the level of the liquid. It denotes the level of the liquid more accurately than the upper limit of flatness in the case of pneumo-hydrothorax, for a vesicular resonance is not propagated below the level of the liquid like the tympanitic resonance; at all events, not nearly to the same extent. The vesicular resonance is due to the lung which floats upon the liquid. I now cause the patient to lie on his back. In this position the liquid gravitates to the posterior part of the chest, and the lung, still floating on the liquid, extends in front downwards. Percussing on the anterior surface, you perceive that the resonance extends several inches lower than when the body was in a vertical position. This test is available in certain cases of pleurisy, but not in all cases. Of course it is not available when the pleural sac is filled. It is not, also, when pleuritic adhesions have taken place, so as to prevent the lung and liquid from obeying the law of gravitation. It is available in the larger proportion of the cases of pleurisy, in which the affected side is not filled with liquid. It is almost always available in hydrothorax.

There is an interesting fact connected with the percussion sound over the lung of the affected side, when the side is partially filled with liquid, which I will illustrate in the case before you. I percuss at the upper part of the chest, in front, on the affected side, and compare the sound with that produced by percussing on the healthy side in a corresponding situation. You perceive that the sounds on the two sides differ. On the affected side the resonance is more intense than on the healthy side. It differs also in character; it is less vesicular and higher in pitch on the affected side. The resonance on this side, in fact, is vesiculo-tympanitic. This is the rule under these physical conditions. The resonance over the lung in the side of the chest partially filled with liquid, is usually more intense than in health, and it is always vesiculo-tympanitic in character. The explanation of this fact has given rise, of late, to con-

siderable discussion. I confess my inability to offer a satisfactory explanation, and I shall therefore content myself with simply stating the fact as one determined by clinical observation.* You see, at once, how this intense vesiculo-tympanitic resonance above the level of the liquid, might lead to the error of supposing that pneumo-hydrothorax existed, provided percussion alone were relied upon, and careful attention were not given to the quality of the resonance. The resonance does not lose altogether the vesicular quality; the latter is only diminished. But in pneumo-hydrothorax the resonance above the level of the liquid is purely tympanitic; the vesicular quality is lost.

I shall now direct your attention to the signs, obtained by percussion, which denote solidification of lung as occurring in pneumonia. It is not convenient to bring patients affected with pneumonia into the amphitheatre, but abundant opportunities will be presented for illustrating in the hospital wards the points of which I shall speak.† In the second stage of pneumonia, over the portion of lung solidified, we have generally notable dulness, sometimes flatness, and in some instances a tympanitic resonance which may be considerably intense. If the solidification be complete, *i. e.* all the air cells within a certain portion of lung filled with exudation matter, whatever sound may be elicited by percussion must necessarily be tympanitic; it cannot have any vesicular quality. Whatever resonance emanates from the lung under these circumstances can only come from air in the bronchial tubes. The sound is generally feeble, and we have tympanitic dulness. But in some cases, especially when an upper lobe is solidified, we obtain a considerable amount of tympanitic resonance. The sonorousness will sometimes be found to vary at different periods of the day, according as the bronchial tubes are free or filled with morbid products. It is to be remarked, in passing, that a tympanitic resonance obtained by percussing the lower part of the chest is sometimes transmitted, on the left side from the stomach, when this organ is distended with gas, and, on the right side, from a similar condition of the transverse colon. This may occur when the lungs are free from disease, but the sound is more readily transmitted if the lower lobe be solidified.

It follows from what has been said with regard to the sounds obtained by percussing over solidified lung in pneumonia, that these sounds are not in themselves adequate to the diagnosis. The sounds may be dull, or flat, or tympanitic, neither being distinctive of solidified lung. Signs obtained by other methods are to be brought into requisition, and especially auscultatory signs. The combination of these with the information obtained by percussion, suffices for the diagnosis. If, however, we are obliged to limit ourselves to percussion, we might often arrive at a diagnosis by ascertaining the space over which the dulness or flatness extends, and taking into view certain well-known laws of pneumonia. Pneumonia, when primary, extends generally over an entire lobe, and the lower lobe is first invaded in a vast majority of cases. Now, let me delineate on the chest the relative situations of the upper and lower lobes. Commencing at the spinal column, at a point on a level with the spinous ridge of the scapula, I draw a line with ink, obliquely downwards and forwards, to the space between the fourth and fifth costal cartilages on the left side, and to a point a little lower on the right side. This line represents, with sufficient correctness for practical purposes, the situation of the interlobar fissures, or the divisions between the upper and lower lobes. The middle lobe, on the right side, is, in fact, only a piece of the upper lobe. It is important to recollect the relative positions of the lobes. You see that the greater part of the lower lobe is situated behind. This should have been called the posterior, and the upper the anterior lobe. Bearing in mind that pneumonia, in the vast majority of cases, invades first the lower lobe, you see that we are to seek for the physical signs of this disease mainly on the posterior surface of the chest. Forgetting the relations of the lobes, practitioners are sometimes content to examine the chest in front for the evidence of pneumonia. Another point relating to anatomy suggests itself in this connexion. The right lung is shorter than its fellow. The liver presses the diaphragm upwards, rising to the seventh and sometimes to the sixth rib on a vertical line through the nipple, the height varying in different healthy persons. Over the liver, of course, we have flatness on percussion. Forgetting the height to which the liver extends, practitioners sometimes consider the hepatic flatness as evidence of intra-thoracic disease. I have had my attention called to the flatness produced by percussing over the liver, as evidence of liquid or solidification of lung, in not a few instances.

To return from this digression to the application of percussion to determine, by this method alone, the existence of pneumonia. Suppose in a patient affected with some acute disease, we find dulness or flatness, extending over a space on one side of the chest, corresponding to that occupied by the lower lobe. We ascertain the boundary line between the vesicular resonance and dulness. We delineate this line on the chest with ink, and we perceive that it pursues an oblique course across the chest coincident with the interlobar fissure. We find that the relations of the dulness or flatness, and the vesicular resonance, are not changed by altering the position of the patient, remaining the same when he is sitting or standing, as when he is recumbent. Having ascertained these facts, we may conclude with much positiveness that pneumonia exists. This procedure does not possess very great practical importance, because, by means of percussion and auscultation, the diagnosis of pneumonia presents little or no difficulty. Still, it is worthy of being considered and remembered.

But other affections than pneumonia occasion solidification of lung. Of these, the most frequent and important is tuberculosis. I shall speak of the application of percussion to the diagnosis of tuberculous disease at some length. Irrespective of this affection, solidifidation, more or less complete and extensive, occurs in œdema of lung, in pulmonary apoplexy, in gangrene, and in carcinoma. A solid mass also displaces space which should be occupied by spongy lung in aneurismal or other tumors within the chest. In all these affections, dulness and flatness on percussion are important signs. Percussion alone, in these affections, is not sufficient for the diagnosis. Other methods are to be employed, and in conjunction with the signs obtained from all the methods, symptoms, and the laws of these several affections, are to be considered. The information obtained by percussion is highly important as furnishing evidence of the physical condition, its situation, and its extent; and this evidence, conjoined with that derived from other sources, leads to a knowledge of the pathological condition, or, in other words, the character of the affection.

Before I proceed to consider percussion in tuberculosis, I will speak of its value as furnishing negative information in several affections. There are certain pulmonary affections which do not give rise to physical changes represented by any of the signs obtained by percussion. This is true of bronchitis, both in the ordinary form of this disease and in the rarer and much more dangerous variety called capillary bronchitis. The normal vesicular resonance continues in pure bronchitis, because the air vesicles are unaffected. Now, the symptoms in ordinary and capillary bronchitis would often lead us to suspect that other affections existed, such as pneumonia, pleurisy with effusion and tuberculosis. But these affections do give rise to physical changes which are represented by signs obtained by percussion. Finding these signs wanting, therefore, we are able to exclude the affections. We reach the conclusion that bronchitis only

* In the wards of the Hospital, on the same day that this lecture was given, the fact was illustrated, that in cases of pneumonia affecting the lower lobe, the resonance over the upper lobe on the same side is usually more intense than on the opposite side, and vesiculo-tympanitic in character. The statement of this fact was inadvertently omitted in speaking subsequently of the application of percussion to pneumonia in this lecture.

† The more important of the points were illustrated on the same day in a case of pneumonia affecting the lower and middle lobes of the right lung, and the organs were exhibited to the class, in a clinical lecture, in the amphitheatre, on the succeeding day.

exists, thus, reasoning by way of exclusion as it is called. This is a most important application of percussion. Absence of dulness or flatness, in other words, the presence of the normal signs on percussion, is a fundamental point in the diagnosis of bronchitis. I shall often have occasion to illustrate this fact in our clinical studies during the session.

Percussion is important, in a negative point of view, in the diagnosis of asthma, in affections of the larynx and trachea, and in cases in which foreign bodies have fallen into the air passages, showing that the symptoms are not due to any of the affections which give rise to signs obtained by this method; in other words, enabling us to exclude all those affections.

Another important application is in cases of intercostal neuralgia and of pleurodynia. These affections may give rise to pain which is identical with the pain of pleurisy. They may be accompanied by febrile movement. As regards symptoms, they may simulate pleurisy so far that, by practitioners who do not employ physical exploration, they are frequently confounded with pleurisy. But pleurisy is attended speedily with liquid effusion into the pleural sac, and liquid in this situation is represented by signs obtained by percussion as well as by other methods. With the aid of signs it is generally an easy problem to determine that pleuritic effusion has occurred. It is easy, also, to determine, by the simple fact that the normal resonance on percussion is unaffected, that effusion has not occurred. In this way pleurisy is excluded, and an important error of diagnosis avoided.

In my arrangement of subjects, gentlemen, I had expected to finish the consideration of percussion in this lecture. It remains, however, to speak of the application of this method of exploration in cases of tuberculosis, and to say something respecting the rules to be observed in the practice of percussion, the instruments which may be employed and other points. As I have occupied the hour, I must defer these matters until my next lecture.

Original Communications.

PAPERS ON

MINERAL WATERS AND THEIR USES.

EMBODYING THE TWO DISCOURSES PRONOUNCED BEFORE THE NEW YORK COUNTY MEDICAL SOCIETY.

By HANBURY SMITH, M.D.,

OF NEW YORK.

No. VIII.

The pathological relations of portal congestion may, perhaps, be rendered more easy of comprehension and memory by the following scheme or diagram:

HÆMORRHOIDAL DIATHESIS.

Primary Physical derangement, *portal capillary congestion.*

IMMEDIATE PATHOLOGICAL CONSEQUENCES.

Impeded circulation in the apparatus of digestion and defecation, and deficient depuration of the venous blood returning from it, resulting in—

Gastric, duodenal, or colonic dyspepsia, and following these, œsophageal and pharyngeal affections.

Jaundice, gallstones, colics.

Diarrhœa, constipation, piles and other rectal disorders.

Splenic physconia.

The lungs, skin, and kidneys having extra duty thrown on them in order to remove effete matter retained or imperfectly digested matter absorbed, become liable to disease; hence the connexion of recurring attacks of pneumonia, bronchial congestion, one form of asthma, chronic catarrhs, laryngo-tracheal ulceration, skin diseases, etc., with the hæmorrhoidal diathesis.

According to constitutional tendencies and external influences, the disorders of the digestive apparatus naturally engender *diminished vital energy*, shown with reaction in irritative fever, without in anæmia. The effects of impeded portal circulation may be propagated to the general, and result in *passive congestions*, first and most naturally in the organs which, lying contiguous to the more immediately affected ones, are therefore most likely to share in their derangements, nervous or circulatory; second, in any organ however remote. In earlier years and more vigorous constitutions, the local disorder may put on more or less of an inflammatory character, being in such case and thereby at once removed from the category of ailments curable by mineral waters; or a persistent congestive condition of the abdominal contents of more active character may obtain, constituting *abdominal plethora*, and producing at first mere functional disturbances, but if unchecked, predisposing to and ending in organic changes, especially in the pelvic viscera; but, in a vast majority of cases, the congestion is only passive, and though persisting year after year, giving rise to disturbed function and pain or inconvenience, rarely ends in organic mischief. It is to this passive hyperæmia that the French and German writers have applied the term *venosity;* convenient, expressive, and suggestive of the true condition.

In proportion as the anæmic variety of the hæmorrhoidal diathesis persists or is developed, does the migratory tendency of the local congestion increase; hence causes so slight as to be considered inadequate, and therefore habitually overlooked, are followed by effects often in important organs, rarely indeed threatening existence, but sadly embittering it. Probably by much the largest half of confirmed invalidism may be thus explained. Too long or too jarring a ride in a carriage, or a degree of cold apparently too inconsiderable to be worthy of taking precautions against, may produce a colic that shall prove most obstinate, recurring again and again on slighter and slighter provocation, and susceptible of but little effective relief by ordinary medication, but disappearing spontaneously either on the occurrence of piles in any of the accustomed forms, or by the migration of the congestion to some other organ or locality. A trifling exertion of the voice in the fresh air may induce a pharyngeal catarrh, in which the obstinate hawking will wear out the patience of both physician and sufferer, and indeed may sometimes pave the way to fatal complications in the respiratory organs. One of the most annoying circumstances connected with these anæmic cases is a congestion of submucous tissue just sufficient to arrest secretion, and obstinately remaining at that point; the converse as it were of the blennorrhœa characterizing parallel affections in the scrofulous diathesis. The rectum, vagina, and pharynx suffer most frequently in this way, giving rise to many obvious and some very common annoyances. All local applications fail in giving more than the most temporary relief, if even that; the only cure is the removal of the diathesic vice.

Disturbances in the innervation of the organs affected with passive congestion in the hæmorrhoidal subject follow as a matter of course, simple hyperæsthesia being by far the most common; no words need be wasted on them; their cure is the modification of the diathesis.

Assuming these views to be correct, I proceed to insist that no means are known comparable to mineral waters in the power of fulfilling the intentions thus presented. To render the biliary secretion free and healthy, without lowering the tone of the system or deteriorating the quality of the blood; to restore, if necessary to increase, the suppressed or scanty secretions of mucous membranes, kidneys, and skin; to invigorate the digestive functions; and by doing these things to equalize the circulation, to relieve local congestion, if desirable to derive from a given organ: all these tasks mineral waters perform in a most satisfactory manner. In their employment, however, we must take into consideration another element besides the chemical composition, namely the *temperature.*

That low temperature is one of the important sources of the effects of cold mineral waters, is evident; for when simple cold water is taken into the stomach, especially the first thing in the morning, it occasions a sense of cold there, diminishes irritability, and lowers functional activity in nerves, bloodvessels, and muscular fibre. If the quantity ingested be large, or the temperature very low, its effects are felt in the whole system, occasioning shivering, retarded pulse and respiration, and diminished or arrested function in every part. Then follows reaction, with increase of warmth, of secretions in stomach, intestines, kidneys, and skin, of functional activity in nervous system and bloodvessels, and a general feeling of well-being. The daily repetition of this process, especially before any part of the digestive apparatus has been called upon to perform any duty, soon diminishes morbid irritability, and restores functional activity to the chylopoietic viscera, while relief of local congestion follows, and by a restoration of healthy character to the blood, the whole system recovers a persistent vigor.

Hot water, again, within certain limits of temperature, occasions an agreeable sense of warmth in the stomach, and increases the flow of blood to that organ, as well as its functional activity. This effect extends, and is soon felt, first in the abdominal viscera, then in the whole system. Every vital process is spurred to increased activity. The pulse beats fuller and faster, respiration becomes deeper and quicker, absorption is hastened, and the secretions of the liver, stomach, intestinal tube, kidneys, skin, and lungs, are increased. If the heat of the water is excessive, or quantity too great, the circulation is much affected, and palpitation of the heart, full and rapid pulse, and congestions in head and lungs occur, not without danger. On their high temperature then depends much of the great power exerted by thermal waters, in restoring secretions, relieving congestions, occasioning absorption, hastening and invigorating all organic vital processes, and thus changing for the better the whole constitution.

When mineral waters are taken tepid, or rather the nearer their temperature approaches that of the body, the more do we obtain *only the pure medicinal effects of the ingredients*, without excitement direct or indirect.

For the relief of the class of disorders of the abdominal and pelvic viscera, last under our consideration, there is no rival to Carlsbad, a hot, alkaline, glauber-salt water; but then no medicinal agent requires more care in administration, more deliberation before prescribing. In this water the glauber salt, acting as a revulsive on the intestinal canal, considerably modifies the exciting effect of the heat; while the iron and manganese render its tonic influence more permanent, and prevent the powerful solvent effects of its alkaline ingredients from proving too debilitating. It is, however, often advisable to follow up a course of Carlsbad, after allowing an interval of two or three weeks, with some simple strong chalybeate, as Pyrmont or Spa. There are a great many springs at Carlsbad of the same chemical composition very nearly, but differing in temperature according as the distance increases from the central subterranean cauldron; and it is found that to produce the most profound alterative action, and to arouse the functions of the kidneys and skin more particularly, the hottest springs are the best; to increase the action of the intestinal canal those which are cooler, and to secure simple alterative action, resolution of congestion, restoration of mucous secretion, the coolest, whose temperature is 135° Fahr.

It is not generally advisable that Carlsbad should purge, which it is not apt to do, though the bowels should not be allowed to become constipated during its use. After a time it is quite common for critical evacuations of fœtid urine overloaded with effete material to occur, or alvine discharges abounding in mucous, bilious, sometimes fatty matters, offensive and tarry, after which rapid convalescence may be expected.

Carlsbad may be prescribed in the graver forms of most of the chronic disorders of the liver and digestive apparatus which we have been considering. In enlarged and in movable spleen it displays great curative power. If occasioned by intermittent, the use of the water sometimes developes a single fit of ague and fever, after which the splenetic physconia speedily subsides. In obscure cases of tic douloureux and migraine, commonly sympathetic with some marked or latent disorder of the digestive apparatus, Carlsbad proves curative when every other treatment fails of giving relief. Space will permit me to say no more on this spring. I will only caution not to prescribe it in any case of disorganizing disease, or where the vital powers are much enfeebled, and will relate one case in illustration of its powers in the hæmorrhoidal diathesis.

A farmer in Ohio, of marked bilious temperament, after twenty years of habitual piles, and occasional attacks of lumbago, became afflicted with sciatica. When I first saw him his sufferings had gradually increased during a year, in spite of the treatment of several respectable practitioners, until he had been compelled to pass five months of agony mainly on his hands and knees, partially supported by bedding and the strong arms of his numerous family. Any other posture rendered his suffering unbearable. The result of my own treatment was to enable him to hobble on crutches round his farm yard, with a wasted and still very painful left leg. In this condition he commenced the use of Carlsbad in May, 1856. At the end of the first week he laid aside one crutch, at the end of the second, the other; the cane followed; and after only four weeks' exclusively internal use of the waters he started on a journey of 800 miles entirely free of pain and rapidly recovering strength. I saw him last in the winter of 1858–9 a hale and hearty man, never having suffered a day's sickness since his journey, and entirely quit of both piles and lumbago.

Where there is too much irritability to admit of the use of Carlsbad, Ems, a milder and cooler alkaline water, may be substituted, but in such cases I generally prefer the cold waters; and of these the Rakoczi of Kissingen stands at the head. Singularly parallel with Congress in composition, it differs in containing one third less water, and in possessing five times as much iron. In the simple hæmorrhoidal diathesis, and in all disorders depending thereon, it is as nearly a specific as can be found for any disease. With it I have cured cases of bleeding piles existing from childhood in a young man of nineteen, and in his father for forty years. The Elizabethan spring of Homburg most resembles Kissingen in composition, but containing a large proportion of chloride of calcium and carbonate of lime, it is more heating and irritating than the latter, and cannot be used when the functions of the stomach and duodenum are much weakened or disturbed. The only other two waters I shall mention as peculiarly applicable to the cases before us, are Marienbad and Franzensbad, the latter to be considered as a milder form of the former, alkaline-glauber-salt. Marienbad is peculiarly adapted to the florid muscular man of means, with indigestion, hepatic engorgement, inaction of the bowels, or hæmorrhoidal congestion, from leading a too luxurious and self-indulgent life without sufficient exercise. Carlsbad would be dangerously stimulating to such a one; Kissingen too rich in iron; the cooling, relaxing Marienbad is the water, but it should be taken very freely in a regular course.

SEVERE GUN-SHOT WOUND OF BRAIN.

LOSS OF LARGE QUANTITY OF CEREBRAL SUBSTANCE—RECOVERY.

BY GEO. B. WILLSON, M.D.

PORT HURON, MICH.

On June 2, 1860, I was sent for, to see a man, æt. 20, some sixteen miles distant, who had been injured by the explosion of a gun the day previous. The messenger stated that a part of the gun-barrel had been blown completely through the forehead of the patient, and had escaped at the back of the head. Two doctors hadibeen called to see him a few hours after the accident, but faled to extract a large

piece of iron which yet remained within the skull. On reaching the house I learned that the patient had, on the day previous, attempted to discharge an old shot-gun which exploded, and that some parts of the stock, or barrel, or of both, were lodged in his head. He was at first knocked down, but after a few minutes was able, with a little assistance, to walk into the house. Since the accident he had retained consciousness unimpaired, and could talk rationally and with ease. His forehead felt sore, and he complained much of pain in his left eye, but otherwise did not suffer.

Every attempt to move the iron produced a feeling "like tearing his eye out," as he expressed it. He was lying in bed with his forehead and one eye bandaged; skin natural; pulse slow, and rather full but quite compressible, 64 per minute; breathing normal; tongue showed nothing unusual; mind comparatively composed, the only anxiety manifested being to have the metal extracted; intellect clear, and rational; sensation and motion unimpaired. I removed the bandages, and found the tissues around the left eye much swollen, the conjunctiva highly injected with blood, and the ball itself protruding considerably. His forehead was blackened and burnt with powder, and presented a large irregular opening, over two inches in length, from below upwards, and an inch in width. The upper part of the opening tapered to an obtuse point, so that it had a somewhat triangular outline, the long angle of which was upwards, and reached a point about half way between the left frontal eminence and the mesian line of the frontal bone, at the upper part of the forehead; the base corresponding with the inner half of the superciliary ridge of the same side. From this opening disintegrated brain substance oozed out quite freely, and according to the statement of the attendants amounted to half-a-dozen tablespoonfuls.

On careful examination of the wound a small portion of a screw which was imbedded in the brain showed itself. I soon found that the screw must be connected with other iron imbedded in the brain; for I found, on introducing my finger, that I could not reach its head, as it passed through another piece of metal at right angles. This latter piece of iron felt wider than my finger, and ran in a slanting direction from below upwards, and from before backwards. From its position and direction I decided that the screw passed through it near its middle forming a T; the screw being the stem, and the unseen body the top of the T. One arm of the T was probably hooked down behind the posterior edge of the roof of the orbit and lesser wing of the sphenoid, in the middle fossa of the base of the skull; its point projecting into the sphenoidal fissure, and pressing upon the nerves and tissues at the posterior part of the orbit. This would account for the protrusion of the eye, and the pain experienced when tension was made on the screw. The other arm extended upwards and backwards, towards the vertex, and probably reached to, and lay up against, the under surface of the skull near the top of the head, to one side of the falx cerebri. This would account for my inability to lift the first arm upwards, from behind the lesser wing of the sphenoid, by using the screw as a lever. It seemed probable that, in such attempts, the extremity of the upper arm struck against the under surface of the skull, and thus prevented the elevation of the body. All this was merely guessing, for I could not prove its correctness: but, as it agreed best with what I could observe, I determined to act upon it.

The indication was to push the presenting part of the screw upwards and backwards, so as to tilt the upper arm slightly downwards and backwards from the under surface of the skull, and give it room to play; and then to lift it upwards and backwards, so as to raise the lower arm from behind the lesser wing. This it was impossible to do; for, in attempting it, the edge of the skull at the upper part of the wound would not admit of the raising of the screw. If the screw was a little shorter, so that it would pass *under* the edge of the skull, it would do, but it was impossible, as it was situated, to cut it off. Or, if the screw could be shoved downwards, so as to get its point within the skull, the manœuvre could be effected; but there was danger of injuring some part of the base of the brain in so doing. I tried it, however, and did not succeed. Wondering at this, I put my finger down again by the screw, and discovered that it was slightly bent just where it came through the other piece, and this bend prevented its passage back. The only way left then, was to cut away a portion of the skull at the upper part of the wound, and thus give the screw space for the necessary movement. If my opinion as to the position of things and the cause of the difficulty, was correct, this would enable us to succeed; but if not, we would have wasted so much skull for no use. However, deeming a small piece of skull of but little consequence in such a case, and being fully supported in my view by the opinion of Dr. Crowell, who assisted me, I determined to enlarge the opening. I raised a small portion of the scalp, and with the bone forceps excised a small V-shaped portion. In a few minutes I had the satisfaction of lifting out the mass from its bed, and proving, that as to shape and position of the pieces, my inferences had been correct. The mass consisted of the *screw*, about three inches in length, and the *breech-pin* of the gun, through the middle of which the screw passed at nearly right angles. The breech-pin was a piece of iron about the size and shape of a good-sized little finger, slightly tapering at one end to a tolerably sharp point, and at the other end being cylindrical and blunt, and of about five-eighths of an inch in diameter. The large end had lain upwards, and the pointed end downwards, and, being small enough at the point, had probably protruded into the back part of the orbit. The next step was to find and extract such other fragments of iron or bone as had been driven into the brain by the explosion. As the cavity now seemed quite large—in fact as if all the anterior and a part of the middle lobe of that hemisphere had been destroyed, I did not hesitate to scoop out the disorganized cerebral substance with considerable freedom; and I do not think there could have been much less than a teacupful extracted. I then probed the wound deeply with my finger; and in passing it back where the larger end of the breech-pin had lain, I felt, at the depth of over 4½ inches (by measurement), two pieces of bone plate, each nearly half an inch in diameter, lying back in the *posterior* lobe of the cerebrum. These I extracted with long narrow forceps, and afterwards several smaller pieces, and many particles—mere crumbs—of bone from other parts of the cavity. After gently scraping the torn and bruised walls of the cavity, and cleansing the edges and surfaces of the membranes, I put a plug of oiled patent lint into the wound, securing by adhesive strips and a bandage.

During the operation I had a chance to discover the amount of sensibility which the brain possessed. I inserted my finger as far as it would reach back on a level with the hole in the skull, and then inquired after the sensations of the patient. He answered that he felt something in his head as large as the body taken out. In answer to another question, he said:—"It is about the middle of my head, with its furthest end nearly between my ears, but a little to the left side." I then put my finger in as far as I could, so as to cover half the metacarpal bone also, and asked, "Do you feel it moving?" "Yes." "How deep is it in now?" "It is further back than my ears: it is near the back of my head." "Does it feel hard like iron?" "No, it is soft. It is your finger." I pressed a little with my finger, and asked, "Does that hurt?" "No." "Do you feel a pressure on any part?" "Yes, away in, far." I then put my finger on other parts, and on the *surface* of the brain, under the skull, and in each instance he could indicate the place. Then, taking a pair of long blunt forceps, I inserted them back into the wound, and inquired as to the sensation. He said that the substance was smaller than my finger and harder; that it felt like cold iron; and so on: showing that the sensation of touch was perfect, though there was no tenderness. His appreciation, too, of the difference of tempera-

ture, or its conduction, was shown by his saying that the iron "felt cold." When I expressed some surprise at the accuracy of sensation, he laughed and said,—"Why, I can feel everything in there, just as plainly as in any other part of my body."

After the dressing, his pulse had increased in frequency to seventy-six, and in all respects he seemed quite natural, and expressed himself as "feeling much better and quite comfortable," and having no pain or soreness except in his eye.

I ordered cool cloths to the swelled eye, and making a small opening at the lower part of the wound, for escape of matter, I directed him to lie on his left side and partly on his face, and promised to see him again on the third or fourth day.

On the fourth day I revisited him. He had needed no medicine, and taken none. The cerebral substance had grown so as to fill the cavity to the skull. I cleansed the surface, and then made a small conical compress of lint and covered it with oiled chamois skin, and laid it into the opening, so as to press upon the cerebral mass. I then strapped it down tightly with adhesive straps, at the same time drawing the edges of the scalp tightly around the periphery of the oiled compress; and reapplied a bandage. I then gave his attendants very particular directions about dressing it, and forewarned them of the danger of *hernia cerebri*. I told them to be sure not to allow the brain to protrude, but to strap the compress down tightly as they had seen me do, and to dress it every day—making the compress smaller at each dressing.

On the evening of the third day after they sent, saying that they could not prevent hernia cerebri; that it had gained on them each day, and now protruded some distance. I lost no time in seeing him, and found that firm compression was so painful that they had given up the attempt and left him to chance a second time. I told him he must bear the pain *nolens volens;* so taking a firm compress of oiled chamois stuffed with pressed cotton, I strapped it down so tightly that I got the tumor well within the cranium. I then gave them still more strict injunctions, and left a compress of pressed sponge to be wrapped in chamois and used the next time. I told them that if they could not get the tumor back at the next dressing they must send for me without waiting longer. I then left, promising to see him again in five days, should my attendance not be needed sooner. They saw that he did not complain or oppose me when in dressing the wound I hurt him much more than they; so, taking courage from that, they succeeded in preventing subsequent protrusion. I omitted to mention that the eye was nearly well at my previous visit, and quite well at this one. I visited him at the appointed times, but there was nothing in those visits worth reporting. In five weeks from the first dressing the external wound was closed. He was able to walk about in less than three weeks after the accident, and felt well most of the time, having to take medicine internally only twice. At the end of the fifth week he was discharged with proper directions as to when to begin making attempts to stoop over, and how to follow them up. He has been very careful since as to his exercise, but he is able to attend to his duties (those of a farmer's boy) as usual, and feels quite well and strong as before.

LITHOTOMY.—ALLARTON'S OPERATION.

By J. GRAFTON, M.D.,

BROWNVILLE, JEFFERSON CO., N. Y.

As the question, What shall be "the operation" for stone? is again before the surgical world, and can only be safely decided by carefully recorded statistical results, I offer for publication in your pages the following case, which, aside from its statistical bearing, otherwise possesses no peculiar points of interest worthy of record.

The patient, J. S. Allen, of Oswego county, æt. fifty-seven, has been troubled with symptoms of stone for the past sixteen years, has experienced forty or fifty attacks of severe urinary hemorrhage, has passed for a number of years large quantities of mucus and muco-purulent matter; is now, prior to the operation, totally unable to retain his urine; micturition being attended with severe spasm and prolapsus ani. On the 8th of July, 1861, I placed him under the full influence of chloroform, introduced a medium-sized staff, grooved on its convexity, into the bladder, and immediately struck the stone, which being heard and felt by all present, I at once introduced the forefinger of my left hand, well oiled, into the rectum (which had previously been emptied), as far as the prostate gland, directing its anterior surface towards the staff, and pressed firmly upon it so as to assist in holding it securely in its proper position.

A narrow straight bistoury, with its cutting edge directed upwards, was then passed directly in front of the anus, deeply down in the groove of the staff, which it struck readily, penetrating the membranous portion of the urethra, directly in front of the prostate gland. After moving the point of the knife from side to side, in the groove of the staff, to assure me of its safe lodgment there; I next made an incision directly upwards towards the bulb, of sufficient extent to admit the tip of my forefinger, and during the withdrawal of the knife from its deep position, made the external wound directly upwards in the middle line towards the scrotum, depressing the handle of the knife towards the symphysis so as to avoid wounding the bulb. The forefinger, well oiled, was then passed into the wound, the slit in the membranous portion of the urethra being readily found, and the finger passed slowly onwards with a rotary motion into the bladder, the staff serving as a director, which was now withdrawn, the forceps passed into the bladder, and the stone, which measured three and three-quarter inches in circumference, extracted. The amount of blood lost during and subsequent to the operation did not exceed two ounces. In this operation I was ably assisted by my kind friends Dr. Lyman Buckly, of Sandy Creek, Oswego co., and Drs. Kinney and Clark, of Mannsville, Jefferson co. The after-treatment was ably conducted by Dr. Buckly. In a few days the patient was convalescent and able to leave his bed, passing water in a full stream, with considerable force, by the urethra; returned home sixteen days after the operation with the wound healed; has within the month travelled twenty-six miles on foot.

Should the chief casualty urged against this so-called Allarton operation, "large size of the stone," occur, what would be the objection against enlarging the external wound downwards through the anterior wall of the rectum, the deep wound backwards through the centre of the prostate, for two-thirds or more of its extent? converting this operation in fact into Lloyd's, which he has adopted in his practice at St. Bartholomew's Hospital, London, with uniform success for many years?

THE FRENCH AND THE ENGLISH.—The public documents of 1859 show that the mortality in that year in Great Britain was at the rate of 2·196 per cent., in France 2·670, but this latter is considerably above the average of that empire, owing to the prevalence at that time of dysentery, diphtheria, and some other epidemics. The marriage rate in Great Britain was 1·650 per cent., in France 1·638. The birth rate in Great Britain was 3·482, in France 2·778. Thus the marriage rate and the birth rate being lower in France than in Great Britain, and the death-rate higher, the natural increase of population is less in France than in Great Britain. The births in France in 1859 were 1,011,787; there is no record of the births in Ireland, but it is estimated that the births in the United Kingdom amounted to nearly the same number; but the deaths in France were 972,556, while the deaths in the United Kingdom were estimated at not exceeding 651,171, fewer deaths by 300,000, with about an equal number of births.—*British Med. Journal.*

Reports of Hospitals.

BELLEVUE HOSPITAL.

SERVICE OF DR. STEPHEN SMITH.

STRICTURE OF THE URETHRA.

[Reported by HENRY M. LYMAN, M.D., House Surgeon.]

Impermeable Stricture—Perineal Section—Death.

H. Y., æt. 42, a native of Germany, a book-keeper by trade, and a moderate drinker, was admitted to the hospital on the 13th of April. Thirteen years previously he had suffered from gonorrhœa. A stricture of the urethra was the result. The constriction became gradually worse, and last winter the patient was driven to the hospital for relief. At that time, it was with the greatest difficulty that any instrument could be introduced; but, obtaining relief from the more urgent symptoms, he left the hospital. April 15th, he again entered the hospital, on account of increased difficulty of urination. Two days after admission, the urine ceased to flow, and the distended bladder could be felt above the pubes. Full doses of Dover's powder were administered, and the patient was placed in a warm bath; a small quantity of urine made its escape at this time. April 16th.—Complete retention; the bladder rising nearly to the umbilicus. The repetition of the opiate and the bath afforded partial relief.

April 17th, 2 P.M.—The same condition continuing, and all attempts to place a catheter, a sound, or a bougie, in the bladder having failed, it was decided that an operation must be performed for the relief of the patient. A steel sound (No. 8) was passed down to the bulbous portion of the urethra, at which point it was arrested by the stricture. An incision was then made through the perineum, and carried forward to the point of the sound. A very small director was gradually insinuated through the stricture—a sharp-pointed bistoury following in its groove. After twenty minutes employed in this dissection, the limits of the stricture—which occupied fully an inch of the bulbous and membranous portions of the urethra—were passed, and the sound slipped easily into the bladder. A catheter (No. 12) was introduced, and the patient was carried to his bed. Pulse 82, steady and moderately full. April 18th.—Patient slept well during the night; pulse 72. 6 P.M.—Pulse 92, full. April 19th.—Did not sleep during the night. Tongue white, pulse 72, not very full. No appearance of inflammation about the perineal incision. The catheter was removed and cleaned. April 20th.—Another restless night, pulse not accelerated, Dover's powder at bedtime. April 21st.—Rested well during the night, catheter again removed. Small granulations forming in the wound. 6 P.M.—Skin hot; pulse 104. Spiritus Mindereri. April 22d.—Pulse 112, small, skin slightly moist. Ordered to take whiskey, milk, and eggs, every hour an ounce. April 23d.—Tongue cleaner, pulse fuller, 115. Patient seems stronger. 6 P.M.—Pulse 126, small; secretion of urine less copious; slightly delirious. April 24th, 7 A.M.—An abundant discharge of tarry fetid stools; pulse feeble, 130. Less delirium than on the previous evening, but the catheter brought no urine from the bladder; the surface of the perineal wound was dry and glossy. Cups were applied to the loins, and a large dose of pulvis purgans was administered. 9 A.M.—No change; the cups were reapplied. 1 P.M.—The catheter brings about half an ounce of turbid urine. The cups and the drug were repeated, and the patient was placed in a warm bath. There was a constant, mild delirium. 5 P.M.—Breathing rapid and laborious; pulse almost imperceptible; tongue slightly brown; skin soft and moist; delirium constant and more active; bowels freely evacuated. 6 P.M.—Pulseless. An hour later the patient was seized with convulsive shuddering and died.

Sectio cadaveris, forty-two hours after death. *Head.*—There was marked congestion of the posterior cerebral meninges, more intense on the left than on the right. No abnormal effusion under the arachnoid, nor into the ventricles. The substance of the brain was healthy. *Thorax.*—The lungs and pleuræ were perfectly healthy. The heart was large, soft, and flabby. *Abdomen.*—The peritoneum was healthy. The spleen weighed 14 oz., but appeared to be healthy. The liver was soft and flabby, it weighed 4 lbs. 6 oz. The weight of the right kidney was only one ounce; the organ was darkly congested, very soft and oily. The left kidney was large and soft, its cut surfaces oozed oil. Its weight was seven ounces. The coats of the bladder presented no unusual appearance. The prostate body was considerably enlarged, but without obstruction of the urethra from that cause. The urethra, excepting that portion which had been the seat of stricture, was normal in its appearance. There was, however, a diverticulum, large enough to contain an English walnut, situated on the under side of the canal, two inches anterior to the triangular ligament. This pouch occupied a portion of the intermuscular space of the spongy portion of the urethra, with which it communicated by an orifice as wide as its own greatest diameter. It was not lined by mucous membrane, and appeared to be of long standing, as if it had been the cavity of an old peri-urethral abscess.

Progress of Medical Science.

PREPARED BY E. H. JANES, M.D.

Results of some Trials of the Hypophosphites in the Treatment of Phthisis. By JAMES RISDON BENNETT, M.D.—The confidence which Dr. Churchill claims for these salts is founded upon his theory, that tubercular diseases have their origin in a diminution of the oxidizable phosphorus contained in the body, the deficiency of which he attempts to supply by the administration of the hypophosphites of lime and soda, which he says he has found by experiment to be the best adapted for insuring the absorption and assimilation of the deficient element, while the hyperphosphite of lime, by supplying another element assumed to be deficient in the tubercular constitution, he thinks specially adapted to certain cases. Neither the theory nor practice is confirmed by other pathologists and therapeutists. According to Becquerel and Rodier, the phosphate of lime is present in an increased quantity in the blood of phthisis, and Beneke affirms, that in all cases of tuberculosis with emaciation, the earthy phosphates in the urine are increased; neither have we sufficient therapeutical evidence to commend these salts to that degree of confidence claimed by Dr. Churchill. Dr. Bennett confines his remarks to cases treated by himself, having no reference to the experience of others. Of the large number of cases in which the trial was made, he reports twenty in the *Med. Times and Gazette*, in eleven of which the disease steadily advanced while under treatment, giving no evidence at all of improvement. Of the remaining nine, four only manifested any decided improvement, of the permanency of which there were no proofs in any one instance. In the cases reported, the hypophosphate of soda was the salt used, though the salt of lime he has employed in many instances, with results not differing materially from those of the soda salt. Of the two, however, he is disposed to prefer that of lime. The only special influence (if any) exerted on any one function of the body seemed to be on the digestive functions, the tongue, in many instances, improving in appearance, and the appetite increasing; but he questions whether this has not been as much from the abstinence from all remedies capable of deranging the stomach, as from any direct influence executed by the phosphatic salt; or whether a little lime water or citrate of magnesia would not have had the same effect; or, assuming that the new remedy has been useful in allaying irritability of the stomach, and improving digestion—effects resulting from

small doses of alkalies—whether this may not be due to the base, rather than the acid with which it is combined. In many instances of gastric derangement, interfering with all treatment, and with the taking of the most simple food, emaciation and debility rapidly increasing, he has found the saccharated solution of lime, according to a formula recommended by Dr. Clelland in the *Edinburgh Medical Journal* for August, 1859, in doses of from twenty to thirty minims three times a day, prove of signal service, acting not only as an antacid but as a tonic. Independent of the action of these salts on the stomach, and intestinal and pulmonary mucous membrane, Dr. B. sees no evidence of any specific anti-tubercular effects. A trial, however, may elucidate the benefit that occurs, in many instances, from a temporary or entire abandonment of other remedies, and the adherence to regulated diet, and the hygienic means, of such paramount importance in all cases of tubercular disease. It may be added, that the cases were taken without any selection, except that such as presented urgent special symptoms requiring immediate attention were not considered eligible. The remedy was given three times a day, generally in an infusion of quassia, accompanied by a meat diet and porter.

Hooping-Cough.—A recent number of the London *Med. Times and Gazette* contains a letter from M. Foster, F.R.S.C., on the virtues of the common clover hay as a remedy in hooping cough. He has used it since last summer in about fifty cases, and found it to fail only in three or four. While other symptoms are to be met with emetics, aperients, salines, and tonics, it relieves the cough of its spasmodic character in a few days. He says it acts best when given so as to slightly affect the bowels. The hay should be sweet and leafy. The formulæ are :—℞ Trifolii in fœno. ℥ ij ; aq. bullient. Oj ; macerate for four hours, and strain. A child five years old may take a tablespoonful three times a day. A syrup is prepared as follows :—℞ Trifol. in fœn. ℥ ijss ; sacch. cand. ℥ ij ; aq. bullient. Oj. ; macerate the hay in the water for an hour with gentle heat, then boil down to proper consistence. A child five years old may take two teaspoonfuls four times a day. A fluid extract is also prepared.

Glycerine and Camphor in arresting the Secretion of Milk.—Dr. Harriss, of Savannah, employs a saturated solution of camphor in glycerine, in preference to belladonna. It is gently applied over the surface of the breast by means of flannel, several times a day. The same solution, with the addition of four grains of tannin to the ounce, is of utility in sore nipples.

Croup, its Varieties and Treatment.—Dr. E. Whittle, senior surgeon to the South Dispensary, Liverpool, believes (*Dub. Quart. Jour. of Med. Sci.*), that the uncertainty among medical men, as to the best mode of treating croup, arises, in some measure, from the confounding of different forms of laryngeal affections, which require, in some respects, different treatment. He divides the affection into seven varieties, which, though strictly speaking they cannot all be called croup, yet are all affections of the larynx, attended with constriction of the glottis, and are often confounded together under the name of croup. 1. Cynanche trachealis of Cullen; true croup, with formation of false membrane, characterized by the suddenness of the attack, and often proving rapidly fatal if relief is not early afforded. In the treatment of this variety, he has long tince abandoned the old plan of bleeding, and giving calomel and tartar emetic freely; but is more successful by having recourse, in the first instance, to the warm bath and an emetic, followed, if the symptoms persist, by small doses of Dover's powder and nitrate of potash. If the tongue is foul, or the bowels loaded, a dose or two of calomel accompanies the first doses of Dover's powder. Should the disease progress, he would resort early to tracheotomy, before the strength is too much reduced, or the false membrane is deposited far down the trachea. 2. The angina stridula of Bretonneau; pseudo croup of Guersant; acute asthma of Millar, characterized by spasm of the glottis, excited by the inflamed and thickened condition of the mucous membrane of the larynx and trachea, without formation of false membrane. It commences with an occasional hoarse cough, exciting little attention for the first few days, when the breathing becomes croupy, and the cough assumes a sharp, ringing, barking sound. This is, in Liverpool, the most common, dangerous, and fatal form of croup, and almost universally confounded with cynanche trachealis. A little temporary relief may be afforded by the old routine of leeching, emetics, calomel, and antimony; but, after a few hours, the breathing becomes more stridulous, the symptoms rapidly increase in severity, and unless tracheotomy be performed, the child soon dies of suffocation. The treatment of this form of croup does not differ from the preceding; but the point is to attend to it before the urgent symptoms come on, and persevere until the shrill barking cough disappears. Should the case be neglected until the breathing becomes croupy, no time should be lost, but tracheotomy at once resorted to. It is in this form of croup that the operation is pre-eminently successful, there being no false membrane to obstruct the tube. Bretonneau describes this disease as of little importance, which may be true in the dry climate of central France; but our author insists that in the cold, damp climate of England, particularly in the winter months, this affection is the forerunner of the most fatal form of croup. 3. Croup complicated with diphtheria, which is diphtheria extending into the larynx, the only treatment for which is tracheotomy. 4. Symptomatic croup, sometimes met with in the early stages of the exanthematous diseases. If treated à cynanche trachealis, the rash will generally make its appearance, and the croup subside. This should not be confounded with that form of croup often met with in the advanced stages of rubeola, scarlatina, variola, etc. 5. Croup caused by an ulcerated condition of the larynx, either syphilitic, or following the ulcerated throat of scarlatina or variola. The immediate cause of the croupy breathing is spasm, excited by the irritation of the ulcers, and may be often treated successfully by tracheotomy. These cases require the topical application of a solution of nitrate of silver to the larynx. 6. Mechanical croup, from œdema of the larynx, etc., can only be relieved by a timely operation. 7. Nervous croup; laryngismus stridulus, purely a nervous affection, generally a complication of dentition, and mostly met with in families of a strumous diathesis. It comes on suddenly, with a convulsion of more or less severity, followed by a shrill, gasping inspiration, something like a whoop after a paroxysm of hooping-cough. The attack may be short, but repeated once or twice in the same night, and it sometimes happens that the child is suffocated at the very outset. With regard to the treatment of this affection, he simply alludes to it as consisting, at the time of the paroxysm, in dashing cold water on the child's face, plunging his feet into hot water, or anything which will give a sudden shock to the system, and in the intervals strengthening the child by the use of tonics, and by having it almost constantly in the open air.

Surgeon of the 18th Regiment of Mass. Vols.—After Cobb's battery of light artillery was about ready to leave for the seat of war, it was discovered that it would be received into the U. S. service as a company merely. This course caused the resignation of the staff officers, and Dr. D. P. Smith, of Springfield, Mass., whose appointment as their Surgeon we have noticed, was immediately appointed Surgeon-in-chief of the 18th Regiment Mass. Volunteers, for three years. Our readers will remember that this regiment passed through New York a short time since, *en route* for the seat of war. It is now encamped on Arlington Heights, Virginia, near Fort Corcoran, and forms part of the first brigade of Gen. Porter's division of the Army of the Potomac.

The Pennsylvania Medical Board is sitting daily, at Willard's hotel, examining medical officers attached to regiments which left that state before they were transferred to the state authorities.

Reports of Societies.

NEW YORK PATHOLOGICAL SOCIETY.

Stated Meeting, Sept. 25th, 1861.

Dr. A. C. Post, President, in the Chair.

INJURY OF SKULL.—CONVULSIONS—RECOVERY.

Dr. Conant presented a small piece of skull removed from a child, aged six years, who, a week ago last Saturday, while playing upon a balcony, fell a distance of twelve feet, striking the left side of the head upon the edge of an iron grating. A physician in the neighborhood was sent for, who, not comprehending the nature of the injury, simply prescribed cold applications. Soon after, the child became more or less unconscious. Coma soon succeeded, and also convulsions on the side opposite the injury. The friends, becoming much alarmed, sent for Dr. Conant, who arrived about three hours after the accident. On examination, it was ascertained that a portion of bone, about an inch in length and half an inch in breadth, was depressed in the situation of the left parietal bos. A crucial incision was made over this part, when it was found that a fracture with depression extended horizontally across the crown of the head, almost to the opposite parietal bos; also, another ridge, with a corresponding depression, which extended backwards and downwards nearly to the foramen magnum. The portions of depressed bone that were separated were removed, but, notwithstanding this, the convulsions still continued. An elevator was then introduced under the exposed edges of the skull, and the depressed portions were raised to their normal position; the severity of the symptoms still remaining unabated, Dr. C. grasped a small piece of sponge with a bull-dog forceps, and carried it between the dura mater and bone in a direction downwards. The sponge soon became saturated with blood and was removed, when the convulsions almost immediately ceased, and the child was a little conscious. The sponge was introduced a second time, and again some fluid blood was absorbed. The following night was passed very comfortably by the patient; cold water was applied to the head and an anodyne administered. On Monday, two days after the operation, the child became a little fretful, and being crossed by his mother, was seized with another convulsion lasting two or three minutes. According to directions previously given, chloroform was administered, and in the course of an hour afterwards, Dr. C. saw the patient; the pulse was very quiet, soft, and compressible. On Tuesday, the child was attacked with three more convulsions, and yet the pulse was not very much excited. On Wednesday morning, Dr. Conant was sent for, with the intelligence that the patient had been in convulsions for two hours, and on his arrival, found that the convulsions were confined to the *left side*, they having previously been upon the right. The thought occurred to Dr. Conant, that this convulsion was caused by some injury to the spinal cord, which had been received during the fall. Chloroform succeeded in quieting the convulsions, but that same evening the left arm became paralysed. A blister was applied, aconite and veratrum viride were prescribed in suitable doses. On Thursday, the patient began to use the arm a little, and in about two days he was able to control the actions of the hand. Since then he has had no unfavorable symptom. At the end of a week from the day he was injured, he was sitting up in his bed feeling very comfortable. The portions of the skull which were previously depressed were, when the patient was last seen, becoming quite firm.

SYPHILITIC DISEASE OF BRAIN.

Dr. Finnell exhibited a portion of the cerebrum, removed from the body of a man thirty-four years of age, who, up to eighteen months before his death, was in the usual enjoyment of health. At that time he contracted syphilis, and in the course of a few months well marked evidences of secondary disease showed themselves. He suffered from sore throat, periosteal swellings, and a general disturbed state of health. When first affected, commenced taking medicine largely and freely, firmly impressed with the idea that it was the only way to get rid of his trouble. Being a politician, he necessarily was subjected at times to violent mental excitement, but in addition to this, he commenced drinking. The consequence of this was a steady progress for the worst until about a month previous to his death, when he was seized with a convulsion. This passed off after a few moments, and he was able to be about again. He had a second attack ten days after, and the third which he had on the day of his death (Saturday last), was soon followed by coma and thus terminated his existence.

Autopsy.—The brain presented well-marked evidences of inflammation, there being a large amount of serous effusion beneath the arachnoid, with yellow patches of fibrine scattered over the surface. In each lateral ventricle there was a teaspoonful of yellow pus.

He also presented the small portion of a clot removed from one of the lateral sinuses. He considered the case as one of syphilitic disease of the meninges of the brain, brought about by intemperate habits, imprudent medication, and intense mental excitement.

CASE OF NECROSIS.

Dr. Krackowizer presented specimens of necrosed bone, and remarked that they were of interest, as illustrating a point in operative surgery, in reference to the time during which the operation should be performed. He thought a good deal of harm could be done by operating too early, and an equal amount of mischief by postponement. The proper time to choose for such a proceeding was, as in the specimen presented, when the sequestrum was merely imbedded in the soft granulations which sprouted out of the involucrum.

The patient was a boy seven years of age, who, two years ago, was seized with symptoms of osteitis in the medullary canal of the right tibia, which, in time, formed an abscess, discharging from the front of the tibia by means of several sinuses. Through each of the openings a probe being passed struck dead bone. An operation was advised and accordingly performed. A T-shaped incision was made on the anterior portion of the tibia, and the flaps were dissected up, exposing the involucrum, which was formed of the compact tissue of the tibia. This was removed. There were two or three cloacæ on the outer aspect of the limb, which, on account of the thickness of bone between them, were united by means of Heine's osteotome, an exceedingly useful instrument for such purposes. The cavity of the involucrum being exposed, was found to be filled with velvet-like granulations, over which were scattered pieces of sequestrum, which could be lifted out with the greatest ease. The boy, since the operation, has done remarkably well, the wound being nearly filled up with granulations.

TUMOR OF NECK COMPOSED OF AN AGGREGATION OF SEBACEOUS FOLLICLES.

Dr. Krackowizer next exhibited a tumor removed from the left side of the neck of a patient forty-five years of age. The disease first appeared about three or four years before as a small nodule, and increased gradually without giving rise to any pain. The patient did not think at first that it was worth while to have anything done until persuaded differently by his friends, when he applied irritating plasters, which resulted in the formation of excoriations and numerous superficial bleedings. The tumor was situated upon the sterno-cleido-mastoid muscle, near the point where it was crossed by the external jugular vein; it seemed to be closely connected with the skin, which on the surface was of a pale reddish color. The papillary substance seemed to be in the state of a warty hypertrophy, the epidermis peeling off in various sized scales. It sprang up

from the surface of the skin pretty abruptly, with a narrow neck, which was overspread in a mushroom-like form. Semi-lunar incisions were made, and the mass was dissected out in the usual way. It showed on its attached surface, where it overlaid the superficial fascia, that it was composed of an aggregation of cysts, through which shone their contents, consisting of a yellowish amber-colored fluid. On closer examination, it proved to be an aggregation of sebaceous follicles, the like of which, in such a situation, he had never seen before; the surface was marked by some openings more or less oval or elongated, which allowed the probe to enter to some depth into the substance of the tumor. The fluid contained within the cyst was made up of shrivelled epithelial scales, and an unlimited quantity of oil globules aggregated in greater or less quantities; the cyst wall was lined on its interior by the laminated substance common to atheromatous cysts.

American Medical Times.

SATURDAY, OCTOBER 12, 1861.

THE PRELIMINARY EDUCATION OF MEDICAL STUDENTS.

There is no literary institution in the United States that does not put every student that seeks to enter its halls to the test of a rigid examination in the elementary branches of learning. If not found proficient, or not to have attained the required standard, he is refused admission, and compelled to turn back and qualify himself for those higher studies, or seek some employment better suited to his talents and acquirements. We are not aware that any one has complained that this system is too rigid, or that it is unjust. No one has even suggested that it were better to allow every student who applies for admission to the classes of our literary institutions to go through a regular course unchallenged and obtain what education he could, urging that thereby he would be a more useful man than he possibly could be uneducated. The position would certainly not be irrational, and might be maintained with a good array of arguments. On the contrary, all interested in the cause of education unite in sustaining the system, and give the best support to the colleges whose examination is most stringent. Nor do the professors in these institutions complain that by being thus careful in guarding the portals to the halls of learning they so effect a diminution of their classes as to endanger the very existence of their respective schools. There exists among them a spirit of emulation which exhibits itself in efforts to graduate classes well appointed by education to take high rank in subsequent life, rather than in measures to simply swell numbers regardless of their educational qualifications. The true measure of success with them is not the quantity but the quality of the material manufactured.

Should a literary institution be established which admitted whoever chose to apply, without an inquiry as to the moral character or preliminary education of the applicant until the completion of the prescribed course, we can have no doubt as to the rank which it would take. It might boast of well filled halls, of overflowing classes, of a long catalogue of patrons, but it would never refer to the educational character of its graduates—the real test of its merits. Such a literary college would soon become a hissing and a byword among the educated, and would speedily sink under the load of infamy which it would call down upon its devoted head by such a prostitution of its powers. It would be repudiated by every honorable and high-minded student, and its diploma would be little better than if issued by the Castle of Indolence. Its testimonial of proficiency in learning would be but a price set upon idleness, incompetency, and demerit.

While our literary institutions exhibit such commendable zeal in behalf of a high standard of education, and consider their chief excellence to rest in the character and not the number of their graduates, our institutions for medical learning pursue a diametrically opposite policy. They esteem the true measure of success to be the number of their graduates, and not the proficiency of these graduates in medical science. Their doors are not only thrown widely open and every one invited to enter, but, in some cases, their servants have been sent out into the highways and byways to compel students to come in that their lecture-rooms might be full. No test questions must be put to such guests, lest they should take it as an insult and attend a neighboring school. The only preliminary examination ever instituted, that we are aware of, was as to the *color* of the student. Some schools have not even the courage to exact the stipulated fee lest they should give offence and diminish their classes, while nearly all swell their lists with the names of many who are not full students of medicine. Under the title "beneficiaries" many colleges contrive to admit large classes who are totally unfit for the study, and much more the practice of medicine. All colleges agree in waiving an examination into the moral character and qualifications, by preliminary education, of the student, until he has completed the course of three years of study, and an attendancee upon two full courses of lectures. And what if he is then found unqualified? Ah! but who ever heard of a medical student after "three years' study and an attendance upon two full courses of lectures, the last of which was in *this institution*," who was not found qualified? It is too cruel after three years of study, and especially after having attended the last full course of lectures (and paid his fees) at "*this* institution," to tell him flatly that he is not qualified to practise medicine. And what an amount of assurance on the part of a Faculty would it not require to do their whole duty in many instances, and candidly inform the candidate that he has altogether mistaken his calling; that he was never qualified, either by natural or acquired mental force, or by early education, for the profession of medicine; that, in a word, he has wasted both time and money in his present pursuit, and must now, after fulfilling all the required terms for graduation, except passing a "satisfactory examination," give up the course of life which he and his friends had marked out for him, and seek some more congenial avocation. No Medical Faculty, however high-minded, would have the moral courage to take from a student his time, and his hard-earned fees, and then deliberately tell him the truth in regard to his qualifications. Many conscientious professors, anxious to do their duty to the profession, and yet sympathizing with the student, whose future life trembles in the balance, are annually put on the rack. With many a doubt, and much hesitation, they at last yield to the force of that policy which makes it too late to deny the student, when he is first put to the test of a rigid exami-

nation. Thus many of our best schools are betrayed into granting their diplomas to graduates who not only disgrace them, but who hang like a millstone around the neck of legitimate medicine. It is from this class that quackery, to the everlasting shame of the medical educating bodies, gains its recruits. Nor can we expect better things until a radical and complete reform is made in our system of medical education. And that reform is suggested by the practice of literary institutions of examining candidates on their first application for admission to the course of instruction. No consideration, other than the desire to do justice primarily to the student, and secondarily to the school, could then influence the judgment of the examiner. If the applicant were disqualified by want of natural abilities to acquire a proper knowledge of medicine, he would unhesitatingly inform him, and thus doubtless would persuade him to abandon a pursuit for which he was not adapted. If he were but partially qualified by preliminary education, we would advise him to establish first the basis upon which he was to build. Thus the profession would be saved the infliction of membership with the incompetent and uneducated graduates which now annually swell its ranks.

Although the institution of this reform, and its practical fulfilment, rests with the medical schools, yet the experience of the past has taught us that the impelling power is with the great body of the profession. While the false idea of merit obtains among colleges that the size, and not the educational excellence of the graduating classes, is to be regarded, no reform can be expected. The profession at large must destroy this false and pernicious system, create a new standard, and bring the schools to its test. We are glad to notice that this first step in the reform of our system of medical education is already attracting much and deserved attention. In the Medical Society of the State of New York, Prof. Howard Townsend has brought it prominently forward in an able report; in the Indiana State Medical Society it has also been urged in an elaborate report; and at the last meeting of the General Council of Medical Education, England, the report upon medical education contains, as its first proposition, the examination of students as to their having acquired the prescribed preliminary education.

We are but too well aware that the subject of medical education is a trite and hackneyed theme. It has been discussed in all our societies, local and general, until it would seem that no new aspect of the subject could be presented; certainly until all have become thoroughly tired of listening to the reports and debates to which it invariably gives rise. Few of our readers will, we fear, even have the courage to glance down the column bearing its caption, to learn what may perchance be the particular topic discussed, and the arguments brought forward. Nevertheless, it is a subject with which no one should become weary, as it is of vital importance to his own respectability, and the social position of his profession. Certainly no one who studies to promote the best interests of that profession will ever become indifferent to the character of his associates as influenced by education. We believe, therefore, to a certain number the subject of medical education has still much interest, and that suggestions in regard to it will not fall on ears indifferent to their importance.

THE WEEK.

The appointment of quacks to the medical staff of the volunteer regiments seems to be a growing evil. From the Army of the West we learn that men are elevated to these positions who have not a shadow of qualification, and often not a diploma. This fault is chargeable on commanding officers, who disregard all forms, and select a favorite without a thought as to his fitness for the position. In this manner some of the most notorious charlatans have even found their way to the staff of the general officer. But we were not prepared to learn that the Board of Medical Examiners, at Washington, composed of some of the best officers of the regular staff, would allow a mere pretender to receive its endorsement, and be elevated to the honorable rank of Brigade Surgeon. Yet from a letter which appears in another column from Dr. Stephen Wickes, President of the Essex Co. (N. J.) Medical Society, to the Surgeon-General, such appears to be the fact. There must have been, however, some inadvertence in this action. Were not the Examiners too much influenced by private testimonials, for we understand the applicant was well fortified with certificates of medical qualification by a prominent surgeon of this city? We cannot believe that the regular staff, which has always so carefully guarded admission to its ranks as to select only those possessing the highest medical qualifications, could knowingly indorse a man as a qualified brigade surgeon who has not even a diploma. If this error has occurred we do not doubt it will be promptly corrected. We should regret exceedingly to find the name of a quack associated hereafter with the honored names of Hamilton, Blackman, Dalton, Hewitt, Bell, Lyman, Suckley, Ellsworth, Crosby, and others which make up the catalogue of Brigade Surgeons.

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In the corps of Brigade Surgeons New York City is well represented. The following appointments have thus far been made:—Frank H. Hamilton, M.D., Professor in the Bellevue Hospital Medical College; John C. Dalton, M.D., Professor in the College of Physicians and Surgeons; Rufus K. Browne, M.D., Professor in the New York Medical College; Henry S. Hewitt, M.D., formerly Surgeon in the U. S. A.; George Suckley, M.D., formerly Surgeon in the U. S. A.; Wm. H. Church, M.D., Surgeon to Bellevue Hospital; Rufus H. Gilbert, M.D., late Surgeon to Col. Duryea's Regiment; John McNulty, M.D., late Surgeon to the 37th Regt. N. Y. Vols.

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Referring to the clause of the new rules and regulations on Medical Education, about to go into effect in England, which provides for the preliminary examination of medical students, the *Lancet* says:—

"There can be no room for doubt as to the propriety or expediency of the proceeding. It is the beginning of an entirely new system, which must tend greatly to improve the general status of the profession. It ensures that no one shall enter the medical profession who has not had a sufficient general education, and proceeds on the sound principle that the general education must precede the professional. No one can be registered as a student of medicine who has not passed the preliminary examination, which henceforth will become what may be called the medical student's registration examination, certifying that he is ready to enter on the study of medicine. Before many years have passed, we shall wonder that the system of allowing this examination to be deferred until the time of the professional examination had been permitted to con-

tinue so long, and still more shall we wonder that any licensing body had granted its diploma without any examination whatever in general education."

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At the recent meeting of the British Association for the Advancement of Science, Dr. Farr read a paper on the health of the British Army. Referring to the reforms introduced by the Commissions, and the result upon the health of the troops, he says:—

"Under the new system an exact account is kept of the diseases of every soldier from the day he enters to the day he leaves the army or dies on the pension list; and the returns are so arranged as to exhibit the diseases of every regiment separately, as well as the amount of disability, invaliding, and death produced by each malady, and as far as possible by each conspicuous cause. The variable sanitary state of the army is thus brought clearly before the eyes of the Medical Department, the commanding officers, the Commander-in-Chief, and the Secretary of State, so that evils, instantly known, can often be suppressed as they arise. The books are now made portable, and so simplified that they will work in the field as well as in barracks. The efficiency of the army depends primarily on the health of the troops; the health being expressed by the relative numbers of sick and dying out of a given strength. The army at home consists of different arms, and, with embodied militia, its strength in 1859 was 90,753. The army consists of men in the prime of life, between the ages of 20 and 40, generally unmarried, and living hitherto in barracks. We contended that, whereas 17 in 1000 of these men at home had died annually, a body so selected, well fed, well lodged, and well handled, morally and physically—admitting only recruits satisfactory to the examining medical officer, and parting constantly with its invalids—should not experience a higher rate of mortality than that expressed by 7 in 1000; the rate of mortality actually experienced by the population at the corresponding ages in the healthy districts of England. The result was nearly achieved in the corps at home in 1859. The mortality of the Foot Guards had been 20 per 1000 (1837–46), and fell to 9; that of the infantry of the line had been 18, and fell to 8; which was also the mortality of the cavalry, the engineers, and the artillery. Some obvious sanitary arrangements were introduced; instead of being shut up in towns the men were sent to healthy camps, and the above are some of the results. The annual deaths among all arms of the service at home had been 17·5; the deaths at Shorncliffe and Aldershott in the three years 1857–58–59 were at the rate of 5 in 1000. The previous excess was referable to zymotic diseases, such as fevers, cholera, diarrhœa, and to consumption; the effects of crowding in barracks, of bad ventilation, bad water, bad drainage, badly chosen sites, bad cooking arrangements, and the absence of the means of cleanliness. A great result has been realized; in England hundreds of lives have been saved; indeed, a battalion living in arms at the end of the year 1859 would, at the previous rates, have then lain buried in their graves. Severe sickness has also decreased, and the vigor of the whole body of healthier men has, no doubt, increased in proportion."

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Board of Health, Philadelphia.—Dr. Thomas Stewartson has been appointed a member of the Board of Health, in place of Dr. Bond deceased.

Health of San Francisco.—Whole number of deaths for July, 125, of which 45 were under three years of age.

Buffalo Medical College.—The *Buffalo Med. and Surg. Jour. and Rept.* states that the President of the Navy Medical Examining Board stated to a candidate that this was "the only school from which candidates have not been rejected during the recent examination for the Government service."

Reviews.

The Principles and Practice of Obstetrics. By Gunning S. Bedford, A.M., M.D., Prof. of Obstetrics, the Diseases of Women and Children, and Clinical Obstetrics, in the University of New York; Author of "Clinical Lectures on the Diseases of Women and Children." Illustrated by Four Colored Lithographic Plates and Ninety-nine Wood Engravings. 8vo. pp. 763. New York: Samuel S. & William Wood, 389 Broadway. 1861.

(*Continued from page* 224.)

The remainder of the book is devoted to labor. The phenomena of natural labor and the duties of the attendant, the accidents that may complicate it, and the various circumstances that may require the intervention of art, are elaborately considered.

In natural labor either extremity of the fœtal ovoid may present. This is not a mere theoretical point, but one of practical importance. If presentations of the pelvic extremity are to be regarded as natural, then it follows that they should, equally with head presentations, be intrusted to nature, until her incompetency to achieve delivery with safety either to mother or child is demonstrated.

This classification of our author, though differing from that of some modern authorities, is in our opinion correct. Equally so is his estimate of presentations of the face as natural. These varieties of natural presentation are considered previous to the description of the phenomena of natural labors. There are certain points of interest connected with face and breech presentations, upon which we had designed to comment, but must pass by for want of space.

In the twenty-fifth lecture our author introduces the young practitioner into the lying-in chamber, and initiates him into the mysteries of his duties there. Punctuality and promptness in responding to the call are insisted on. Having gathered important information from the nurse, he is at length ushered into the presence of his patient.

"You approach her gently and courteously, and, * * * enter into conversation with her, talking of any and everything except of the subject directly connected with the object of your visit."

After a suitable time has elapsed, a vaginal examination is proposed through the medium of the nurse. "While the nurse is arranging the patient, you will generally be requested for the time being, to walk into an adjoining room; but if not, be careful that you occupy yourself with something else than gazing at the movements of the parties; take a seat, and turn your back; become thoughtful, as if lost in the solution of some great professional problem; or, if a book be at hand, open it, and improve your mind." A most important suggestion follows. When about to address himself to such an examination, the accoucheur is to call to mind that he desires by it to learn—

"1. Is she pregnant? 2. Is she actually in labor, and has the os uteri begun to dilate? 3. Are the pelvis and soft parts in a normal condition, or are they deformed? 4. Is the presentation of the fœtus in accordance with the requirements of natural labor?"

The importance of each of these inquiries is forcibly illustrated by cases and arguments.

The phenomena of the three stages of labor are now described, and the conduct of the practitioner and the management of the patient under each. In this connexion our author enunciates an axiom which may be unhesitatingly accepted, viz.—"*You should, as a general rule, regard quick births as dangerous.*"

A lesson of great importance is enjoined upon the young practitioner, which he should carry in mind through life; "the moment the child is in the world, place your hand

gently upon the hypogastric region of your patient, for the purpose of being assured that the uterus responds to the birth." A general observance of this rule would without question greatly diminish the frequency of post-partum uterine hemorrhages.

All the duties of the accoucheur in the third stage of labor are described, and attention particularly called to the removal of coagula from the vagina and mouth of the womb, *immediately* upon the expulsion or the withdrawal of the placenta. The latter we believe to be a precaution seldom observed, and yet inferior in importance to no other, as a means of preventing the irregular contractions so often productive of frequent and harassing after pains. Excellent figures illustrate the introduction of the hand to overcome spasm and to remove the placenta.

The lecture upon the duties and conduct of the accoucheur will be read with delight by the student, and with profit by the experienced. It cannot be too highly commended.

Lecture twenty-seven is devoted to the consideration of uterine hemorrhage. Our author introduces the consideration of this all-important subject by a graphic portrayal of the scene in the lying-in chamber upon the occurrence of alarming hemorrhage after the birth of the child.

The picture of the miserable inefficiency of him who under such circumstances is overcome by his fears, though painful, is but "too faithful a daguerreotype of many a sad scene in which the heartstrings of affection have been broken, and the domestic hearth converted into a domicile of unutterable grief." That the practitioner may avoid the liability to such sad disaster, the expedient of immediately placing the hand upon the uterus after the expulsion of the child is again urged.

In the treatment of uterine hemorrhage, the one object to be accomplished is to make the uterus contract for the purpose of closing the mouths of the exposed bloodvessels. The use of the tampon is most properly regarded as absurd and dangerous. Pressure and cold are the reliable remedies.

The placenta is to be removed so soon as the uterus has cast it from its surface, and pieces of ice may be advantageously introduced for the purpose of exciting contractions. Ice water into the stomach contributes materially to this result. Dr. Bedford regards compression of the aorta, which has been generally disregarded, as a "sovereign remedy," "not merely, as is generally supposed, because there is no more blood reaching the uterus, but for another reason which has been demonstrated by the experiments of Dr. E. Brown-Séquard, that there is no more certain mode of producing contraction of the womb than by the arrest of the arterial circulation." Injections of cold water into the uterus, as well as the introduction of pieces of ice, have been discountenanced by some as liable to produce metritis. The authority of Scanzoni is quoted in favor of the first of these expedients, while our author regards as unjustifiable and dangerous all stimulating and irritating injections.

To overcome the exhaustion induced by loss of blood, "the various stimulants are to be employed—brandy, milk punch, strong coffee with laudanum, etc., but a due degree of care is to be exercised in their administration, for remember, after a momentary revival, the patient is again apt to fall into collapse. It is as it were, but the last flickering of the light in the socket, there is but one spark left, and if it be too rudely blown it brightens for the instant only to become for ever extinct." The insidious nature of internal hemorrhage is truthfully represented and illustrated by a most instructive case in our author's experience.

The researches of Brown-Séquard, and the labors of Martin of Berlin, have quite recently revived attention to an expedient long since fallen into disuse, viz. the transfusion of blood into the veins. Within the past year, Martin has published an essay, in which it is stated that there are fifty-eight known cases in which this operation has been resorted to, and that in forty-six cases the result was complete recovery, though the exhaustion had been so extreme as to inspire no hope whatever of success. These researches are quoted by our author, and also the researches of Brown-Séquard, which have led that eminent physiologist to the conclusion that the blood of inferior animals, as of dogs and cats, can be substituted for human blood, and that defibrinated blood is equally successful with that freshly drawn. This author's directions for injecting the veins are quoted by Dr. B., but we do not understand him as expressing an opinion upon the merits of the recommendation.

Lecture twenty-eight contains the fullest directions for the Management of the Puerperal Woman and her Infant during the month, and they embrace every topic that can interest the young practitioner.

It is unnecessary to enumerate the familiar topics discussed in this chapter; few subjects are more intimately connected with the success of the young physician. The "running schedule" of inquiries that ought to suggest themselves to the practitioner at his first visit after the delivery of his patient, embraces every point upon which he should inform himself; the analysis of individual symptoms, especially of pains, will serve to direct his treatment. Excellent directions follow as to feeding the infant and treatment of its disorders. An interesting account will be found of milk in the breasts of new-born infants, as also of sore nipples and mammary abscess in the mother.

The subject of the Inversion of the Uterus is inferior in interest to the practitioner of midwifery to no other, since of all the accidents that may occur in the lying-in chamber, this has most frequently served as the basis for suits for malpractice. The question of chief importance is, can this accident occur spontaneously, or does the fact of its occurrence imply neglect or malfeasance on the part of the practitioner? On this point our author says:—

"I think, however, the fact must be conceded that, in the great majority of instances, this form of uterine displacement is due manifestly either to carelessness or gross ignorance on the part of the accoucheur; as an evidence of the truth of this opinion, you will observe that, in well-regulated lying-in hospitals, inversion of the uterus is among the very rare complications of labor. It is an interesting circumstance to record that, in 71,000 cases of delivery, which occurred in the Dublin Lying-in Hospital, there was not a solitary example of inversion. We, therefore, are to look for this accident principally among the records of private practice."

And again:—

'Inversion is occasionally spontaneous, and this would be more likely to occur in women who have borne many children, in whom the muscular parietes of the uterus are very much relaxed, and the labor rapid."

The views here presented of this subject he believes to be essentially just and supported by experience. While no mantle should be woven to screen the careless practitioner from the proper consequences of his misdeeds, it is due to the professional brother to whom this accident may have occurred without fault of his own, that it should be understood that this accident may in some cases have a strictly spontaneous origin. It is impossible to ignore the testimony of some conscientious reporters, that inversion of the uterus has occurred to them, after the expulsion of the child, without the least traction having been made upon the cord. Dr. Channing even reports a case (*Boston Med. and Surg. Journ.*, vol. xl. p. 231), in which the child and afterbirth were rapidly expelled, and the womb inverted, all by the same continued effort. To the direction given by our author, that the hand should be instantly placed over the uterus, upon the expulsion of the child, with a view of ascertaining if it be contracted, it should be added—*and to learn if it be contracted uniformly and not depressed inward at the fundus.* Such dimpling probably precedes every act of inversion of the womb, and may be caused, as we have reason to believe, by irregular action of the muscular fibres—though this opinion, we are aware, is not adopted by all. Such depression of the fundus, if recognised, would put the

attendant upon his guard. On page 448 we find attention called to this point.

In lecture thirty-one, certain accidents are considered, which may render manual delivery necessary.

In prolapsus of the funis our author advises that attempts be made to replace the funis, in accordance with the practice of the Lying-in Hospital of Vienna, in which, of forty-three cases of the accident thirty-eight children were born alive. He also describes the now well known "postural treatment," of Dr. T. G. Thomas, of this city, which promises a large degree of success.

Considerable space is devoted by our author to the subject of Unavoidable Hemorrhage, or that arising from Placenta Prævia. Ample directions are given for the management of the patient in those frequently recurring hemorrhages to which the woman is under such circumstances liable.

We conceive that in the present state of our experience, our author is fully justified in regarding version to be "the cardinal remedy," in placenta prævia, when the head is at the superior strait, and forceps when it has descended into the pelvic excavation. It is true, that the claims of the tampon, rupture of the membranes, employment of ergot, etc., separately and collectively, have been urged as capable, in many cases, of preventing the necessity of version. If the views of Barnes in relation to the line of spontaneous cessation of hemorrhage be eventually proved to be correct, additional ground will be furnished for delay while these expedients may be tried. If it be true that in every case, sooner or later, such a line of separation is reached, that no further hemorrhage is possible, it will be manifestly the duty of the accoucheur to disregard the "cardinal rule" so long as it may seem to him safe to do so, and wait for a natural delivery, thereby greatly increasing the chances of safety to the child.

The merits of Dr. Simpson's plan for artificial detachment of the placenta are now well understood. Nobody now regards it as intended as a substitute for version. We presume there are few who question that Dr. Simpson assigned to the separated surface of the placenta much too large a share in the production of hemorrhage. Our author very properly regards contractions of the uterus the great hæmostatic agent in uterine hemorrhages. In arguing against the probabilities of the success of this expedient, our author inquires: "But suppose the accoucheur, after the birth of the child, should attempt, by *premature* and *forced tractions* on the *umbilical* cord, to hurry the operations of nature, and thereby cause an artificial detachment; would there not, as a necessary consequence, in ninety-five cases out of one hundred, be more or less profuse bleeding?" We answer, most certainly—and more than that, the successive detachments of portions of the placenta, as the os uteri dilates, may be likened in their effects to "the premature and forced tractions" of the cord; and experience proves that in both instances, regular, uniform contraction of the exposed surfaces is secured by the removal of the entire placenta, and consequent cessation of hemorrhage. To be just, however, our author does not depend upon argument as a proper reply to the inquiry as to the success of artificial separation of the placenta. He quotes the fullest and most recent statistics upon this point, which prove beyond question, that to whatever conclusion arguments may lead, the fact is undeniable, that *cessation of hemorrhage may be confidently expected* immediately or very soon after the artificial separation of the organ.

In no particular is the indebtedness of practical medicine to physiology more strongly marked than in the instance of puerperal convulsions. While this disorder was once supposed to depend upon changes in the circulation alone, we now know the causes are various in their origin, and that they may be grouped under the two heads, 1st. Eccentric or external, and 2d. Centric or internal. In Lecture thirty-two our author considers the former of these two classes, their symptoms and treatment. Among the *reflex* causes of convulsions, indigestible food in the stomach stands prominent; this is illustrated by our author in an interesting case. Intestinal irritation may produce a similar effect. A very instructive case, occurring to our author, serves to illustrate the influence of vesical irritation, convulsions having apparently been induced by the strangury caused by the absorption of cantharides from a blister.

From the recognition made by our author of the various sources of convulsions, his denunciation of routinism in treatment naturally arises. The dangers arising from persistence in venesection, and from the use of opium without proper regard for its indications, are dwelt upon at length. Of the importance of an early and free evacuation of the bowels in the convulsions occurring during labor, at least, there can be no doubt. We have seen cases in which venesection and the free use of chloroform failed to arrest the convulsions, yield upon the operation of a cathartic. Dr. Bedford recommends etherization, with the proviso that in all cases of plethora the circulation shall be first equalized by the use of the lancet.

In case of the occurrence of convulsions previous to the dilatation of the os uteri, our author remarks: "I know of no remedy equal to the belladonna, for I am quite satisfied that it possesses two important attributes, one of which, at least, has, perhaps, not been sufficiently appreciated in the practice of midwifery. These attributes are *the lulling of uterine contraction, and the promotion of dilatation of the mouth of the organ.*" He recommends its employment in the form of ℥i of the extract to ℥i of cerate. Dr. Bedford speaks of the results obtained, in the most positive and unequivocal manner.

The thirty-third lecture is devoted to an elaborate discussion of the connexion between albuminuria and puerperal convulsions. Our author's remarks upon this interesting subject will well repay perusal.

The great feature of this book is the portion assigned to Manual and Instrumental Delivery. We have dwelt so long upon the subjects already noticed, that we cannot do justice to the remainder in the space allotted. Some idea may be formed of the extent of discussion and the minuteness of detail, by the fact that four lectures are devoted to manual delivery alone. In the thirty-fourth lecture he considers the various circumstances that may demand the assistance of the hand, embracing the correction of unfavorable positions of the head. The mode of performing podalic version under various positions of the vertex is first described. The account of cephalic version, so long rejected from practice, but recently revived, and especially Dr. Wright's improved directions for its performance and the success attending it, will serve to call the attention of practitioners in this country to an expedient which ought, under certain circumstances, to be preferred to any other.

The practice of performing cephalic version by external manipulation has for some time been largely adopted in Germany, and its claims recognised in other countries on the continent. Circumstances have arisen in this country within the last two years, which have served to bring a knowledge of it for the first time to many of our physicians. As we might expect, from the strictly conservative character of our author's teachings, he discountenances a resort to this operation during the latter months of pregnancy, for the very good reason that statistics prove the strong probability that a transverse presentation detected during gestation will be spontaneously converted into a head presentation by the end of the ninth month.

The propriety of version in pelvic deformities is considered by our author. It was resorted to by Denman and others of his time, but fell into disuse in England. For some years past it has been resorted to in Germany, and has recently been revived in Great Britain. The considerations presented by Dr. Simpson in its favor are quite familiar to the well-read physician. Our author considers that if the antero-posterior diameter of the brim be less than three and one-eighth inches, delivery by version would be impossible; and that in lesser degrees of contraction, it is safer to trust to the moulding influence of continued con-

tractions to enable the head to descend, the forceps being resorted to, so soon as the incompetency of nature is declared. Turning, says our author, "under the most favorable circumstances, is *an operation of peril both for mother and child;* and just in proportion as the natural dimensions of the pelvic canal are abridged, the peril will be enhanced; and, although, as a general rule, when the head is still at the superior strait, I prefer turning to forceps delivery, yet, in the event of a pelvic deformity, such as we have been considering, my choice would be the instrument."

The mode of effecting artificial delivery when required in cases of pelvic presentations, is next considered, followed by a lecture upon the management of transverse presentations under the various positions of the trunk, and with the different complications that are more usually associated with them.

In describing spontaneous evolution, our author states that Douglas has shown that Denman's explanation was erroneous. It would have been more strictly correct to have stated that besides the spontaneous evolution of Denman, Douglas and others have recorded cases of spontaneous version, in which the shoulder is expelled first, and while it presses against the arch of the pubes the chest and breech are successively forced down. Dr. B. states, as evidence of its rarity, that he has never met with an instance of such spontaneous change, and properly cautions the student against expecting such a termination of labor.

The three following lectures are devoted to forceps delivery, and we speak advisedly when we say, that nowhere in the whole range of obstetrical literature, so far as we have read, is this subject treated in greater detail, and certainly not with a more careful appreciation of what is to be reasonably expected from the use of this instrument, and of the conditions under which its employment is justifiable.

Dr. Bedford comments with deserved severity upon the too frequent and unnecessary resort to instrumental delivery, and of the "practice of certain medical gentlemen, who speak of their almost daily use of the vectis, forceps, or crotchet, precisely as if a man's skill in the lying-in room is to be measured by the frequency with which he resorts to instruments! I believe in the converse of this proposition; to my mind, the truly skilful accoucheur rarely (comparatively, at least) employs instruments," because he well knows that "nature is generally adequate to the proper accomplishment of her work."

He remarks, "the obstetric arsenal, so far as the number and kind of forceps are concerned, is not only a vast armory, but has really become an institution in itself; and, indeed, it may be asked, with some degree of propriety, whether the interests of humanity would not have been more wisely served, if some of the time employed in the construction and modification of this instrument, had been given to the proper consideration of the more important question—*Under what circumstances, and in what manner is the Forceps to be Employed?*"

Dr. Bedford dissents from the restricted view, which in the judgment of Dr. Meigs and others would lead us to regard it as "the child's instrument." Repeated aggravated instances of malpractice in attempts at artificial delivery having come under our author's observation, he is unsparing in his rebuke of "those practitioners who destroy their patients by the rude and unjustifiable use of instruments;" and strongly intimates that "the good derived from the forceps has been more than counterbalanced by the evil it has inflicted." This is a fearful question; and when we consider the accidents which occur in the use of forceps, to physicians of unquestioned intelligence, and even accomplished in practical surgery, but unused to the intrument in question, one of little experience may well hesitate before resorting to its employment.

"What is the true power of the forceps?" Some rely much upon its ability to diminish the diameters of the head by compression. Dr. B. admits its power to do this within limits not exceeding three or four lines, without endangering the child. The true office of the forceps our author regards to be that of a *tractor;* "*the forceps as a tractor becomes, as it were, a substitute for the uterine contraction necessary to expel the child. Therefore, in all particulars, it should be made as rigidly as possible to simulate, through extractive force, the uterus as an expulsor.*"

The sources of danger to mother and child are alluded to. We cannot forbear to ask why do lacerations of the vagina or bladder occur in the practice of intelligent men, as we *know* they do happen? We do not believe that they are caused by violent introduction of the instrument, but in consequence of imperfect seizure of the head, and unskilful management in delivery. If the handles be too much elevated, the extremities of the blades may lacerate the vagina posteriorly or even the rectum, and if too much depressed, the bladder may be ruptured. In conducting delivery the practitioner ought ever to be guided by the consideration that "*the forceps being a substitute for the natural forces, should, in every particular, be made to imitate as far as may be these very forces.*" The forceps represented on page 579 are well known to the profession of this country, and have already received "that degree of favor" to which a "fair trial" entitles them.

The conditions calling for the use of forceps are next considered. If the antero-posterior diameter of the brim at the transverse diameter of the outlet be less than three and one-eighth inches, he considers that a living child cannot be delivered.

Dr. Bedford exposes the error of certain of the older English obstetricians, whose rules for the determination of the proper time of delivery were based upon the ability to recognise the ear, and upon the fact that the head had remained without advance for six hours. These rules were doubtless designed to counteract a tendency to the unnecessary resort to the instrument. It would be doing injustice to English authorities of the present day to represent them as adopting these arbitrary directions. We believe that for the most part they would assent to the language of our author, who declares that the proper time is "a question of evidence;" the problem to be solved is, "can nature accomplish the delivery consistently with the safety of parent and child, or will the interposition of science [art?] be needed?" "*Nec temere nec timide,*" should be the maxim; better "*that the instrument should be employed five minutes too early than five minutes too late.*"

Certain obstetricians of the present day seem to take pride in displaying their disregard of long-settled rules of practice. Among these the requirement that the os uteri should be dilated previously to the use of forceps, is professed to be disregarded. Our author expresses his opinion most emphatically, that "to attempt to introduce the blades of the forceps into an undilated os," would be "the probable passport to the death of the patient."

The mode of introducing the forceps is most clearly described and illustrated by several figures. The "rules" for introduction are very explicit, and, as our author remarks, "there is not a direction inculcated which will not be of value to the practitioner." The difficulties do not terminate with the introduction of the instrument.

"Those of you, who have never witnessed a case of forceps application, will be amazed to learn the amount of force sometimes required to achieve the delivery; the strongest arms will occasionally be found almost surrendering to the needed effort; and yet all this force, if it only be tempered with judgment, is not only justifiable, but will be quite consistent with the safety of mother and child."

A slight oversight occurs on p. 595 in describing the introduction of the forceps, when the vertex is at the left acetabulum—it is plain that the male must be passed *under* the female blade or the blades crossed.

Our author takes frequent occasion to inculcate the precept that in the choice of modes of delivery, *version* is to be preferred so long as the head is at the *superior strait* or still within the os uteri, and the *forceps*, whenever the *head*

has passed from the os uteri, and is in the cavity of the pelvis. In cases of moderate contraction of the brim, and in some instances of detention of the head at the superior strait by other causes, our author would resort to the forceps, provided the diameter is not less than three and a quarter inches. He pronounces this "one of the most difficult operations in obstetric surgery." It would be interesting to know the relative mortality to the child of this operation, and of version.

The accoucheur will be occasionally called upon to assist the delivery of the head by forceps, when the feet have been delivered first. Our author expresses the belief that one will almost always succeed in delivering the head by manual operation; and has met with but two cases in which he was obliged to resort to forceps, in both of which there was disproportion between the head and the pelvis. He states that "appalling results occasionally ensue from the rude and unskilful attempt to extract the head by manipulation," but they are concealed from public knowledge, through the privacy of the lying-in-chamber, the friends believing "all was done that could be done." Manipulations under such circumstances are often very difficult, and if the head has passed for the greater part beyond the uterus and closely fits the pelvic cavity, it seems to us that the use of forceps increases the chances of saving the child: but this will depend very much upon the skill of the accoucheur in accomplishing their introduction. We cannot dwell upon the use of the forceps in face presentations.

Lecture forty-one introduces the consideration of delivery by cutting instruments. What is the highest contraction of the pelvis consistent with the birth of a living child? Our author quotes the different estimates of authors, from 2 inches up to 3½ inches. Dr. Bedford's estimate, as we have before seen, is 3⅛ inches. The highest degree of contraction allowing delivery by piecemeal, is also variously estimated from 1 to 2 inches. From repeated experiments Dr. B. would assign 2½ inches as the limit, unless the child be dead. Now between 3⅛ inches, the limit of the birth of a living child, and 2½, the limit of safe embryotomy, what shall be done if the child be living and at full term? This, as we have seem, will include cases of not very infrequent occurrence. Symphyseotomy, of which a very interesting history is given, being properly rejected, shall the child have the chances afforded by the Cæsarean section?

It is most gratifying to see that modern obstetrical science is devoting special consideration to the means by which the loss of fœtal life may be diminished. Dr. Tyler Smith has taken a leading position in this advance, and expresses a hope in the eventual abolition of craniotomy from the practice of midwifery. This result, of course, can be attained only by a more general resort to the induction of premature labor, version (?) and the Cæsarean section, in cases to which they may be severally adapted.

It is but justice to our author to state, that the tendency of his instructions for the last twenty years has been in the same direction. That he has uniformly denounced the resort to craniotomy under circumstances in which it is very often practised, all who have heard him well know; and he has been, so far as we are informed, alone in the position that the Cæsarean section should be resorted to between 3⅛ in the limits of living birth, and 2½ in the limit of safe embryotomy. For the purpose of comparison, we here state, that Tyler Smith, in his Lectures, considers that the forceps are generally inadmissible in diameters below 3¼ inches; that turning may be practicable between 3¼ inches and 2½ inches; the Cæsarean section comes into the field in high distortions of 1½ or 2 inches or less; and between the point at which turning is impracticable, and Cæsarean section indispensable, lies the domain of craniotomy.

This opens at once to us the question of the relative dangers of the Cæsarean section and of embryotomy. On this point we should be pleased to dwell a while; though unable now to shed upon it any new light, we think the source of fallacy in the reasoning of writers is plain. By quotations, our author shows the differences of opinion that exist as to the value of the Cæsarean section. There can be no doubt that much of the difference between English and Continental authorities is based upon religious grounds. Dr. B. quotes Churchill's latest statistics, that give the mortality after embryotomy as 1 in 5. Of 49 cases of embryotomy in the Dublin Lying-in Hospital 16 died, or about 1 in 3. The mortality to mothers in the Cæsarean section is estimated at 1 in 2½, and to the child 1 in 3½. Our author admits that, as compared with craniotomy, the maternal mortality of the abdominal section is the greater, but, he argues, "in the practice of Dr. Clarke, a practitioner of sound judgment and ripe experience, in 49 cases there was the dreadful sacrifice of 65 lives, supposing the children to have been alive at the time of the operation!"

If we are to estimate the trophies of the Cæsarean section, in comparison with those of Craniotomy, by the aggregate of the lives of the children and mothers, the Cæsarean section may result in the preservation, numerically, of a greater number of lives. Here we are brought directly to the relative value attached to the life of the unborn child, in Catholic and Protestant countries. It appears clear to us that the materials do not yet exist, or at any rate have never been properly presented, for a comparison of results between these two expedients. Our author very properly dwells upon the fact that Hysterotomy has been often performed in hopeless cases, and not in accordance with the advice of writers who lived nearly 300 years ago, who urged that "*the Cæsarean operation should be performed before the rude manipulations of the accoucheur had injured, and more or less exhausted the woman.*" Hence the statistics we now possess, doubtless exhibit a rate of mortality considerably higher than is fairly due to the operation itself. Much also may be expected from the use of anæsthetics. But on the other hand we must remember, that the mortality assigned to craniotomy is enormous, if we regard the deaths as in any way connected with delivery. We know that such statistics are composed of cases in which it was resorted to on account of convulsions, hæmorrhage, rupture of the womb, and other accidents. Does any one believe that one out of every five dies from the immediate effects of craniotomy? or at any rate that this need be so, if it be performed with any decent regard for the safety of the mother? But we do not find it equally easy to dissociate the death of the patient from the abdominal incision, no matter how favorable may be the circumstances of its performance. We would not discourage a resort to Cæsarean section in cases to which it is adapted; but it is essential that we should understand plainly, whether it be resorted to because the mortality to the *mother* is less than that of Craniotomy, or because we attach to the life of the unborn fœtus a value that shall warrant the mother incurring very imminent risks to herself. On this point our author speaks plainly, and declares, that "*if the child be alive, the woman at the completion of her pregnancy, and it be made manifest that the maternal passages are so contracted as to render it physically impossible that a living child can be extracted per vias naturales, I should between the two resources—craniotomy and the Cæsarean section—not hesitate to decide in favor of the latter.*"

In taking this ground, our author is aware that he "is at variance with the general views of the profession on this subject." This is certainly true. The fact that, in his own extended experience, he does not appear to have an opportunity of illustrating his views in his own practice, certainly justifies his reputation for the adroit and successful use of the forceps in difficult labors. Statistics of a really reliable character may eventually show, that the danger to the mother from craniotomy, when the diameter but little exceeds two inches, approaches that of the Cæsarean section; but the same can hardly ever be proved to be true when the diameter approaches three inches. Furthermore, it is between the limits of three and a quarter and two and a half inches, that turning has been recommended, and is extensively resorted to on the continent of Europe. The perils incurred by mother and child in this operation will

be thoroughly canvassed, before the warmest advocates for the preservation of the child will make choice of hysterotomy, in the class of cases here referred to. Our author, as we have seen, would not resort to version under such circumstances, believing it to be very hazardous to mother and child; for, if we take even the gross estimate of the mortality to the child of version, as given by Churchill, it is a little over one in three. In the cases we are now considering, however, the pelvis being seriously diminished in capacity, the chances to the child doubtless are less than this estimate. Even then, so far as the child is concerned, as compared with craniotomy, version manifestly must have the advantage.

Rejecting version as unavailable, Dr. Bedford's choice would be between craniotomy and hysterotomy, in which case he would not hesitate to elect the latter; believing that an early resort to the operation, under the use of anæsthetics, would so far diminish its perils as to warrant the mother in taking the risk that she may afford a chance of life to her child. But it must be remembered, that the mortality to the child even in this operation is very great, viz. one in three and a half.

The whole subject of hysterotomy is presented by Dr. Bedford with great ability, especially in connexion with embryotomy, to which the next lecture is devoted. His views cannot fail to command attention, but we do not feel that in the present state of our knowledge we are justified in adopting them in all their breadth.

His denunciations of a frequent resort to craniotomy must meet the hearty accordance of the practitioner of enlightened judgment. The lecture on the induction of premature labor is very complete, and is full of interest. A succinct history of the principal doctrines regarding puerperal fever, with judicious directions for its treatment, occupies the forty-fourth lecture. The volume concludes by a lecture on anæsthetics.

We have now completed the promised survey of this book. In the Preface our author states:—

"I have endeavored to present to the profession a practical book, one which will develop the phenomena of parturition in their various phases as they occur in the lying-in room." * * *

"The arrangement of the work is rigidly systematic." * * *

"I have had in view the wants of the obstetric student; and I have endeavored to aggregate facts, and dispense as far as possible with theoretical discussions. Throughout the work I have maintained strictly a conservative midwifery." * * *

"It has also been my endeavor to inculcate upon the accoucheur a due reverence for the resources of nature, so that he may not thoughtlessly lapse into that too common error—'Meddlesome Midwifery.' Among other things, it has been my special aim to bring the work fully up to the existing state of Obstetric Science in all its varied relations."

We are happy to record our opinion that, in the endeavors here expressed, our author has been eminently successful.

The tone of the book is calculated to inspire the obstetrical student with enthusiasm in his pursuits, as well as with a chivalrous respect for the sex to whose sufferings he is to minister. As already intimated, the practical character of the book is one of its prominent features; and on the few occasions in which the author indulges in theory, the practical view of his subject is not for a moment lost sight of.

The volume bears, to the careful reader, internal evidence of great labor. That no pains have been spared to present everything deemed worthy of attention is evidenced by the list of authorities consulted; and yet it is in no sense a compilation, as this formidable list might lead one to suspect. It contains the substance of Dr. Bedford's teachings for a long series of years, enriched by the contributions of fellow laborers. The design then, in this respect, is perfect, and its satisfactory completion will be a source of congratulation to the author. The volume is illustrated by figures selected for the most part from the best authorities, and on all practical subjects these are abundantly copious. The four admirable plates of the changes in the areola by Montgomery, are reproduced with fidelity.

We hope, in the next edition, to see the subject of reproduction, so well treated in the text, illustrated also by suitable figures. These are indispensable to the student.

For the most part, our author has succeeded in curtailing the redundancy of expression, almost necessarily incident to the lecture room, produced by anxiety to simplify a subject; but he has not been in this respect uniformly successful. His just indignation against the malpractice of pretenders, of which many examples have come under his observation, especially leads him, in certain instances, into a style of narrative too dramatic for the taste of some readers. A copious Table of Contents precedes the first chapter, besides which, a most elaborate alphabetical Index enriches the book. The paper and typography are of the best quality.

In conclusion, we shall have greatly misjudged if this book does not prove an eminent success. Notwithstanding the form of "lectures," the arrangement is rigidly systematic, and therefore well suited for the purposes of a text-book. That it will not only be extensively adopted as such, but held in high esteem by the large class of practitioners who no longer regard works of foreign production as necessarily superior to those of American origin, we have every reason to believe.

JAMES D. TRASK, M.D.

Correspondence.

EXPERIMENTS WITH KEROSOELENE.

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR:—Noticing an article in the MEDICAL TIMES, of Aug. 10, describing a new drug for producing anæsthesia, I sent for a quantity and have been experimenting with it a little. Perhaps my experience in its use may be of benefit to others who may wish to investigate its effects as an anæsthetic. I have taken it to the point of entire insensibility to external impressions and have given it to several others. A sort of numbness is at first felt, and anæsthesia to pricks and pinches occurs long before the person is insensible.

In the cases that I have given it, it has not produced a *sleep* as occurs from the use of chloroform, but a kind of trance in which the mind is still active. No bad effects have remained after its use—no headache, fulness over the eyes, or sickness at the stomach. It does not seem to produce any exhilaration, but acts purely as a sedative. The pulse in one or two instances was somewhat accelerated.

I also gave it twice to a cat. The first time I inserted her head into a boot, having first saturated a piece of cotton with the kerosoelene and placed it in the bottom. She soon became entirely insensible, and remained so for some time; she lay quiet and breathed natural. The next time I gave it, about a week afterwards, I had produced perfect anæsthesia by holding the cotton to her nose, and was just ready to perform a surgical operation upon her, when, without any premonitory symptoms, she straightened out in a kind of convulsion, and giving three terrible groans, died.

Yours, &c.,

GEO. P. CADY, M.D.

NICHOLS, TIOGA CO., N. Y., Sept. 28, 1861.

BREAKING OF A CATHETER IN THE URETHRA.

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR:—As I have barely escaped a serious accident from an imperfect catheter, I wish to call the attention of the Profession to the subject. In order to enforce the point, I will give a synopsis of the case.

CASE.—I. F., aged 50, has for years been afflicted with

dysuria, attended with inability to retain his urine over an hour or two. About fifteen months since, this difficulty resulted in complete retention, which was relieved by the use of the catheter, which, on account of his distance from the physician, was left in the bladder for a few hours, so that he could remove the plug when he felt the necessity, and relieve himself. After pursuing this course for about two weeks, he regained the power to void his urine, but was still able to retain it only a short time. He neglected to use means for a radical cure, and finally, on the 9th of August, 1861, he altogether lost the power to pass the urine. He introduced the catheter once himself, failed on another attempt, and sent for medical assistance. There was some difficulty in the introduction of a metallic instrument, and a total inability to retain it in the bladder, so that it became necessary to use the elastic instrument, which could be retained some eighteen hours without irritation. At about that time the instrument would become coated and softened so as to necessitate the use of a new one. On the 16th of August, about 11 A.M., I introduced a new instrument, which, to external appearance, was as good as any before employed. In order to give the urethra rest from the pressure of the catheter, I visited him twice a day, with directions to remove it a few hours before my arrival. About 3 P.M., on his attempting to withdraw it, it parted about three inches from and within the orifice of the urethra. On learning the fact, I went to his house, taking what instruments I had, and succeeded without much difficulty, by the aid of a pair of long forceps, belonging to my pocket-case, in withdrawing the fragment, which, with the portion before broken off, was very brittle, and would snap asunder on an attempt to bend it. The coating on the article was smooth, and to external appearance perfect, but there was no tenacity, and apparently no fibrous texture. I cannot say what was deficient in the manufacture of the instrument, but, from appearance, it might have been burned. Can it be possible that the action of the urine should have produced the change? Certainly none others purchased at the same time, and apparently similar, were changed in the same manner. They would become soft and roughened. Whatever rendered it thus imperfect, it was a dangerous article, and, if the fracture had occurred a few inches lower, it would have necessitated an operation, which, if not difficult, would, in his condition, have caused future embarrassment, if not serious trouble.

I submit this, hoping it may direct the attention of surgeons, if not manufacturers, to the subject, and thereby prevent accidents. Yours, etc.

E. S. LYMAN, M.D.

SHERBURN, New York, *Sept.* 27, 1861.

Army Medical Intelligence.

ASSISTANT SURGEONS U. S. NAVY.—The following are the names of Assistant Surgeons U. S. Navy, who have recently passed the Board of Naval Medical Examiners, now in session at U. S. Naval Hospital, Brooklyn:—Adolph A. Hoekling, Penn.; Heber Smith, N. Y.; Stephen I. Clark, N. Y.; Lewis Zinzin, N. Y.; Josiah H. Gunning, N. Y.; Edward Kershner, Md.; John W. Bragg, Mass.; Charles H. Perry, R. I.; George E. Brush, N. Y.; Joseph Hugg, N. J.; T. B. Adams Lewis, N. Y.; Samuel R. Foreman, N. J.; Watson C. Hull, N. Y.; Daniel Moore Skinner, N. J.; George I. Shipley, Mass.; Charles Ellery Steadman, Mass.; Wm. Borrow Mann, N. Y.; Isaac H. Hazelton, N. Hampshire; Edw. Duggan Payne, Penn.; Benj. H. Kidder, Mass.; David F. Eickets, Md. The names are given in the order of reporting, and with no reference to relative merit.

MEDICAL NOTES FROM THE ARMY OF WESTERN VIRGINIA.

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR:—At this extraordinary period in our national history, anything from the medical department of our army, relating to the character of its duties, to the difficulties or facilities for discharging them; anything descriptive of its diseases or of peculiarity of wounds received in the field of battle; anything about the treatment of the one or the other, coming from our patriotic band of surgeons, deserves a place in our country's medical record, and will, doubtless, be read with interest by us all. Even casual incidents of camp life and warfare are by no means uninteresting, and will perhaps not be unwelcome occupants of the pages of a medical journal.

With these views, I send you the following extracts from a letter just received from Elkwater, headquarters of Gen. Reynolds's division of the Army of Western Virginia, bearing date of Sept. 14, 1861. The letter is from an old and highly esteemed friend, who, some months ago, at great pecuniary sacrifice, joined one of the Ohio regiments as Surgeon, and has been since in constant active service all over Western Virginia.

His very extended public and private practice for the past twelve years in this city and elsewhere, and his position as public teacher of medicine for some years past, lend peculiar attraction to what he may say of his experience in military medical matters.

Of camp life he says: "We live in tents which are comfortable enough in their way, but not equal at all to houses. The nights are excessively cold, and the days equally hot in such housing. Of course in the field our hospital accommodations are poor, having to use large tents for our shelter, but we get on with them very well. We establish post hospitals in all the villages, wherein our men are well provided for, and consequently the treatment there, being under more favorable circumstances, is followed by more satisfactory results.

"Our medical staff, with few exceptions, are first rate men, and good soldiers. They never flinch from a march at 'double quick' nor any other duty, and are allowed to have pretty much their own way in all that pertains to their department. We, however, cannot prevail upon the Colonels to keep their men clean or their camps in proper condition. A camp of volunteers out here at the end of three weeks, is the filthiest thing imaginable. We perhaps, as a consequence, have typhoid fever and camp dysentery." "By the way, I have had very decided success in the treatment of both this dysentery and diarrhœa with the employment of Rochelle salts purgatives."

Of wounds he says: "Since the commencement of my military career, I have probably personally attended 250 wounded men, and my experience thus far leads me to the following conclusions:

"First, wounds from small rifle bullets—such as deer and squirrel hunters use throughout our country—or buck shot, are seldom dangerous, unless they happen in a vital organ. They rarely break a large bone, or injure the muscular tissues to any considerable extent. They work their way between tissues rather than pierce them, in consequence of being easily deflected from their course. Occasionally, however, they produce bad wounds of arteries, by only partly dividing them, thus leaving them in the most favorable condition for severe hemorrhage; but these small missiles produce little shock. Second, wounds from the Enfield rifle, and the rifled musket, are *always serious*, although they may *appear* but slight. These bullets produce a hideous destruction of tissue, tear bones and everything else to pieces; produce severe shock, extensive sloughing, with great danger of secondary hemorrhage. A wound of this kind resembles a cog-wheel wound, or that from some other crushing machinery, more than anything else, yet this does not describe it. The part is livid, the openings of both entrance and exit are ragged, the latter generally presenting everted edges, with masses and shreds of various tissues protruding from it. Hemorrhage is sometimes very free, at others scarcely any, although the same vessel may be wounded in both cases.

"*I have never seen a recovery from one of these Enfield rifle wounds involving a large bone, where amputation was not performed early;* that is, *was not a primary amputation.* The bone is uniformly comminuted, and the fragments are very sharp, so that the patient will die almost to a cer-

tainty from irritation, and the discharge, if he do not from *gangrene, which is not uncommon, even if the large vessels escape injury.*

"Third, the wounds produced by shells resemble those made by splinters, as at railroad accidents, more than anything I think of. There is usually not much contusion, but frequently much laceration. Sometimes an angular fragment will make a clean cut, followed by free and dangerous hemorrhage. The fragments, if the shell has exploded at some distance, frequently make long lacerated wounds, and penetrate and lodge in the tissues, and are difficult to extract. These wounds are dangerous, but not so bad as those made with any of the *large* rifle bullets, unless the fragments happen to be very large.

"When the explosion takes place very close by, the wounds produced are a combination of burn, laceration, contusion, and perhaps incision, and are attended with great mortality." In reply to some inquiries I recently made of him, he says, "I have seen several bayonet wounds, particularly after the battle of Rich Mountain; they were mostly among the enemy's wounded, and ugly things they are." I made this inquiry for the purpose of eliciting evidence as to the universal truthfulness of Mr. Guthrie's statement, that "*regiments charging with fixed bayonets never meet;*" and that bayonet wounds only occur in occasional personal encounters, or where one party has been cornered, and could not get out of the way. The Doctor does not give us the history of any of his bayonet wounds; hence we see no reason for questioning Mr. Guthrie's accuracy, as yet. He may give us more details in some future letter.

Of broadsword wounds he says: "I have seen none that amounted to anything serious, and cannot but think they are great bugbears. It is possible they may be avoided as a general thing, after the manner Mr. Guthrie states bayonet wounds are avoided, viz. by getting out of the way."

The following extract may not be thought uninteresting, as illustrating the peculiarity of this war. He says: "I was at the capture of Pegram, and among many things saw among the prisoners a late resident physician of New York city, who, upon the outbreak of this rebellion, fled to his native 'sacred soil,' and took up arms against the Government, like many others of the same nativity. I expressed to him my opinion that he was a great scoundrel, and I soon saw that he was a very poor surgeon. His operations on some of his own men were great failures. I cannot but think that the rebellion's loss is the soldier's gain, and that he is what he richly deserves to be—a prisoner."

One other and I am done. He says: "Day before yesterday, a party of our scouts saw a company of cavalry approaching their position. As soon as they came within range they of course were fired upon by our men, and one horseman was seen to fall from his saddle. Our men ran to the fallen horseman, who had been deserted suddenly by his companions, and who was unable to speak, and made every effort to get him into our camp alive, but they failed, he having died on the road. His dress showed him to be an officer, and on examination made it clear that our scouts had killed John A. Washington, the former owner of Mount Vernon. *Three Enfield rifle* bullets had passed through his body. We sent his body to his friends the following morning with a flag of truce. The Colonel who received it was affected to tears, and said there appeared to be something terribly strange about the matter, a kind of fatality he could not comprehend. As you may suppose from what I have said about Enfield rifle wounds, there was little wonder that the unfortunate descendant of our immortal Washington never spoke to his captors."

The doctor closes his letter saying, "I write this almost under fire, our army having been engaged in more or less constant skirmishing for two days past, and the enemy in unsuccessful efforts to flank us and get upon our rear. A number of our men have been brought in wounded during this time, but it is worthy of remark that a large proportion of their wounds are from the small bullets above referred to, and consequently are but few of them serious. They will seldom break a bone larger than a metacarpal. You can from this, form some idea how the enemy in these parts are armed." From other sources we have learned that this skirmishing at Cheat Mountain, above spoken of, resulted on the 16th, two days after the date of his letter, in repulse of the rebels under Lee. I am looking for further accounts from the same author, and shall be happy to extract from them anything you may think desirable for publication.

Yours etc., S. R.

New York, Sept. 28th, 1861.

Protest against the Appointment of a Non-Medical Man to the Office of Brigade Surgeon, by the Essex Co. (N. J.) Medical Society.

[The following correspondence appears in the *Med. and Surg. Reporter.*—Ed. Med. Times.]

Orange, N. J., September 18th, 1861.

C. A. Finley, Esq., M.D., Surgeon-General U. S. A.

Dear Sir:—In behalf, and at the request of the members of the "District Medical Society for the County of Essex, N. J.," I address you in relation to the recent appointment of Mr. John J. Craven, of Newark, to the office of Brigade Surgeon. Mr. Craven is an old resident, and I believe a native of Newark. He has been engaged in various pursuits, as a carpenter, a dealer in merchandise, a keeper of a saloon, etc., till two years ago, when he entered the office of Dr. G. Grant, now Surgeon of the 2d Regiment, N. J. V., for the study of medicine. He remained with him three or four months, when he left his office, and set up for himself as "Doctor Craven." I am informed by the medical gentlemen of Newark, that he has no *medical* or *surgical* knowledge which can avail him in the position to which he has been assigned. He has no diploma; has never attended medical lectures; has no license to practice; and has not the shadow of a claim to a medical status at home. He was surgeon of one of the three months' regiments, having obtained his commission during the times of peace, by virtue of his assumed title, and at a time when medical attainment was not considered necessary in organizing a regimental staff. When his regiment returned, he endeavored to obtain another appointment, but was unable to secure it. The profession of this District is now surprised and mortified by the announcement of his appointment to the responsible post of Brigade Surgeon. I am desired by the members of the Medical Society of this District, in their behalf, to enter a respectful protest, in which I cordially unite, against this appointment of John J. Craven. We do so in vindication of the honor and dignity of the medical profession in this portion of New Jersey. Drs. Dougherty, Osborne, Grant, Oakley, and Woodhull, have gone out from among us as Regimental Surgeons. They are medical men whom we respect and esteem, as well educated and thoroughly competent. We ask in the name of the profession at large, that they shall not be compelled within the camp, to consult with one, who at home does not aspire to an equality with them, and who is known as an irregular and unlicensed practitioner, professional intercourse with whom, on their part, would subject them to censure and expulsion from the ranks of the profession, by a violation of the Code of Medical Ethics which it is their ambition to honor and magnify. We feel assured that you will be pleased to know the facts as above detailed, and the feelings of the profession here in regard to them, and that they will receive such attention at your hands as the circumstances of the case will allow.

I am, very respectfully,
Your obedient servant,
Stephen Wickes,
President Dist. Med. Soc'y of the Co. of Essex, N. J.
Attest: Hiram H. Tichenor,
Sec'y of Dist. Med. Soc. of Essex Co.

TO CORRESPONDENTS.

Student—"*What is the average weight of a normal ovary in adult life?*"—According to Prof. Gross (*Elements Path. Anat.*), one drachm and a quarter. He says:—"In eight young females, who died between the ages of 17 and 28, and in whom, from their previous health and moral habits, there was every reason to believe that the ovaries were perfectly natural, I found the mean weight to be *one drachm and a quarter*, the maximum one drachm two scruples and a half, and the minimum fifty-six grains."

W. K. S. (U. S. N.)—Communication received and will appear next week.

Erratum.—In the last week's paper, on page 227, first column, thirteenth line from bottom, for "*uterus*," read *volume*.

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK,

From the 22d day of September to the 28th day of September, 1861.

Abstract of the Official Report.

Deaths.—Men, 72; women, 58; boys, 119; girls, 98—total, 347. Adults 130; children, 217; males, 191; females, 156; colored, 6. Infants under two years of age, 141. Children reported of native parents, 18; foreign, 169.

Among the causes of death we notice:—Apoplexy, 5; Infantile convulsions, 24; croup, 4; diphtheria, 5; scarlet fever, 12; typhus and typhoid fevers, 3; cholera infantum, 25; cholera morbus, 1; consumption, 47; small-pox, 7; dropsy of head, 18; infantile-marasmus, 38; diarrhœa and dysentery, 22; inflammation of brain, 18; of bowels, 9; of lungs, 13; bronchitis, 2; congestion of brain, 8; of lungs, 5; erysipelas, 1; whooping cough, 3; measles, 1. 183 deaths occurred from acute disease, and 108 from violent causes. 239 were native, and 108 foreign; of whom 73 came from Ireland; 4 died in the Immigrant Institution, and 42 in the City Charities; of whom 13 were in the Bellevue Hospital.

Abstract of the Atmospherical Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

Sept. 1861	Barometer.		Temperature.			Difference of dry and wet bulb. Thrm.		Wind.	Mean amount of cloud.	Rain.
	Mean height.	Daily range.	Mean	Min.	Max.	Mean	Max.			
	In.	In	°	°	°	°	°			
22d	29.75	.07	60	54	64	5	8	N.	7.5	
23d	29.87	.17	68	58	78	7	10	W.	1.7	
24th	30.04	.11	65	55	75	9	14	N. W.	.04	
25th	30.06	.05	65	55	75	8·5	13	S. W.	0	
26th	29.94	.19	65	58	72	8	11	S.	1	
27th	29.60	.57	62	53	72	5.5	7	N.E. to SE.	9.8	.27
28th	29.81	.30	63	54	70	8	12	NW to SW.	2	

Remarks.—22d, Light rain early A.M.; clearing P.M. 27th, Hard rain mostly between 3 and 5 P.M. A heavy gale from about 5 P.M., lasted all night, with occasional showers. 28th, Hard wind early A.M., with light rain.

MEDICAL DIARY OF THE WEEK.

Monday, Oct. 14.
- New York Hospital, Dr. Buck, half-past 1 P.M.
- Bellevue Hospital, Dr. Loomis, Is. Hos., half-past 1 P.M.

Tuesday, Oct. 15.
- New York Hospital, Dr. Watson, half-past 1 P.M.
- Bellevue Hospital, Dr. Clark, half-past 1 P.M.

Wednesday, Oct. 16.
- New York Hospital, Dr. Bulkley, half-past 1 P.M.
- Bellevue Hospital, Dr. Sayre, Is. Hos., half-past 1 P.M.
- Academy of Medicine, 8 P.M.

Thursday, Oct. 17.
- New York Hospital, Dr. Buck, half-past 1 P.M.
- Bellevue Hospital, Dr. Elliot, half-past 1 P.M.

Friday, Oct. 18.
- New York Hospital, Dr. Watson, half-past 1 P.M.
- Bellevue Hospital, Dr. Flint, half-past 1 P.M.

Saturday, Oct. 19.
- New York Hospital, Dr. Bulkley, half-past 1 P.M.
- Bellevue Hostital, Dr. Parker, half-past 1 P.M.

SPECIAL NOTICES.

New York Ophthalmic School.—Dr. Mark Stephenson *will deliver the Introductory to his Tenth Course of Lectures on Operative Ophthalmic Surgery, at the* N. Y. Ophthalmic School and Hospital, *No. 63 Third Avenue, on Saturday, October 19th, at 4 o'clock P.M. Members of the Profession and Students of Medicine are respectfully invited to attend.*

Academy of Medicine.—*At the next meeting,* Prof. James R. Wood *will read a paper on the "Reproduction of Bone."*

At the first meeting in November, the paper by Dr. I. Parigot, "*On Moral Insanity in relation to Criminals,*" *will be discussed.*

Bellevue Hospital Medical College.—*The opening Exercises in this school will take place on Wednesday next, the 16th inst., at 3 o'clock P.M., at the College Building in the Hospital grounds, when addresses will be made by* Prof. Isaac E. Taylor, *President of the Faculty;* Hon. Simeon Draper, *President of the Board of Trustees;* Prof. B. W. Macready; His Grace Archbishop Hughes; F. Tallman, Esq.; *and* James T. Brady, Esq. *The Medical Profession and Medical Students of New York and Brooklyn are invited to be present.*

At 12 o'clock, the Steamer "Bellevue" will leave Bellevue Hospital for Randall's and Blackwell's Islands, and return at 3 o'clock. Those who may desire to visit the Institutions under the charge of the Commissioners of Charities and Corrections are invited to join in this excursion.

Section of Obstetrics and the Diseases of Women and Children.—*A regular meeting of the Section will be held at the residence of the Chairman,* Dr. Alfred Underhill, *No. 44 East 20th St., on Monday Evening, 21st inst., at 8 o'clock precisely. Subject for Discussion: Scarlatina and its sequels.*

Dr. J. E. Taylor *will exhibit some drawings of the neck of the Uterus in the different stages of pregnancy.*

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References.

Dr John Watson, President Academy of Medicine; Dr. Stephen Smith, Editor American Medical Times; Dr. John H. Griscom, Physician N. Y. Hospital, &c.; Dr. John W. Greene, Physician Bellevue Hospital; Dr. Geo. A. Peters, Surgeon N. Y. and St. Luke's Hospital; Dr. H. D. Bulkley, Physician New York Hospital, and others.

For directions and particulars, more in detail, see Special Circular.

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Meteorology, from the Encyclopædia

Britannica, by Sir J. F. W. Herschel. 12mo. Edinburgh, 1861 $1.60. Bailliere Brothers, 440 Broadway, N. Y.

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do Iron reduced to Hydrogen.
do Officinal Chalk without odor.
do Dragees of Lactate of Iron.
do Ferrugineous of Nancy for Rusty Water.
do Lozenges of Citrate of Iron.
do do of Lactate of Iron.
to Saccharine of Citrate of Iron for Rusty Water.
do Syrup of Citrate of Iron.
do Syrup of Iodide of Iron.
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CASHOO of Bologne.
CAUVIN—Digestive Pills.
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do Depuratif Vegetal.
do Mineral Bath.
do Perfumed Bath.
do Toilet Water for Ladies.
do Anti-Tetter Pomatum.
do Pomatum for Piles.
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